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ABSTRACT

This resource training manual for family advocacy workers is designed to help these workers meet the needs of families who care for adolescents with emotional disabilities. It is intended for use with a companion manual which focuses on the needs of youth themselves, and stresses that effective case management must integrally involve both youths and their adult caregivers. Folllowing an introduction, nine units deal with the following topics: the theory of intervention, the family's role, the caregiver-family advocate partnership, assessment of family strengths and needs, the objective-setting process, key components of program design, strategies for exercising influence, the program goal and standards, and measurement of client satisfaction. Each unit contains objectives, activities, and background information. Appendices contain assessment tools (family demographic profile, family quality of life assessment scale, and child behavior rating scale); a caregiver's service satisfaction survey; and outcome monitoring tools (client contact record and goal statements). (JDD)

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TRAINING MANUAL
FOR FAMILY ADVOCACY
IN-HOME SERVICES

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TRAINING MANUAL
FOR FAMILY ADVOCACY IN-HOME SERVICES

A model of helping families
who care for children
with emotional disabilities

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Training Manual for Family Advocacy In-Home Services

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UNIT 1
INTRODUCTION

Description

This unit describes the purpose of the manual, the target population, extent of the problem, and consequences of the problem.

Objectives

At the conclusion of this unit, trainees will be able to:

1. Understand the purpose of the manual and how to make the best use of it.
2. Describe the population for which the model is designed.
3. Become aware that the problem of emotional disabilities in youths affects a significant number of families.
4. Summarize some of the demands placed upon family caregivers caring for youth with emotional disabilities.
5. Demonstrate an awareness of the type of services most frequently needed by family caregivers.

Activities

1. Team members should begin the process of getting to know each other. The trainer should stress the close working relationship and cooperation required to make the program a success.
2. Trainees should be encouraged to express any anxieties or fear about working with individuals with emotional disturbances.
3. Describe the different ways in which the manual may be used.
4. Describe the population for which the model is designed.
5. List consequences to the youths, their families, and society of emotional disabilities.

UNIT 1
INTRODUCTION

Purpose of the Manual

This resource manual is designed to help workers meet the needs of families who care for adolescents with emotional disabilities. Families who care for children with severe emotional disabilities face phenomenal challenges and demands. The extent to which the family can successfully meet those challenges is the key factor in determining whether these children will be raised in their neighborhood or spend much of their lives in an institution. But despite the indispensable contribution the family can make to caring for youth with emotional disabilities, scant attention has been devoted to its caregiving role. The professional services which have been provided to these families are minimally effective and often create additional problems. Family Advocacy Case Management (FACM) addresses many of these shortcomings.

This manual is intended as a companion to the *Resource Training Manual for Case Management with Adolescents with Emotional Disabilities*. For conciseness and clarity the two manuals focus on the needs of youth and adult caregivers separately; however, a basic premise of the project is that effective case management must integrally involve both groups. Some elements of the two manuals are redundant in order to stress aspects of service delivery which apply to both the youth and their families.

The intended uses of this manual are for training and on-going reference by the workers, who are referred to as family advocates. Initial training of family advocates should include the use of all sections of the manual. After training is completed specific sections of the manual can be referred to as needed. The manual is written and organized to provide quick access to specific subjects.

A value premise integral to this case management model is that caregivers should be given the assistance they need to help their child live their lives in the most normal environments possible. In the vast majority of cases, such an environment will be centered upon the parent(s) (i.e., whoever serves as their parent substitute or adult caregiver in the community). Because the caregiver role is viewed as the essential link to the adolescent's normal community living, it is a major focus of Family Advocacy Case Management.

Target Population

The FACM model is beginning its fourth year. During those four years it has been implemented in a community mental health center and a state hospital. While the model could be used effectively with a variety of populations, the experience referred to here reflects work with families caring for youth with serious emotional disabilities. The Kansas State Department of Mental Health and Retardation Services' definition of severe emotional problems in youth includes the following five characteristics: The individual is under age 18 and exhibits severe behavioral, emotional, or social disabilities. These disabilities disrupt normal development and have persisted for an extended period of time. The disabilities cannot be attributed solely to intellectual, physical, or sensory deficits, and the adolescent frequently requires intensive treatment.

The problems experienced and the behaviors exhibited by children with emotional disturbances are referred to here as "disabilities." This terminology is believed to be less stigmatizing than the typical mental illness labels assigned to these children. Disability no longer engenders the sense of hopelessness which accompanies mental illness. The public has come to understand that a disability can be compensated for, if not all together overcome. The notion of coping with a disability carries with it the implication that with adequate support these individuals

can learn to make the most of their strengths and live successfully in the community.

Thinking of the child's problems as a disability instead of an illness will have a positive effect on the coping efforts of their family caregivers as well. It is the strengthening of these efforts which is the focus of the Family Advocacy Model. Too often the family with a mentally ill child is blamed for the problem and excluded from an active role in treatment. The disability model portrays the family in a more positive and helpful light than the illness model. By so doing it is believed that the family's energies and resources can be directed toward helping their child rather than coping with the stigma associated with the mental illness label.

Extent of the Problem

For a variety of reasons, it is difficult to determine exactly how many youth and their families suffer from the effects of severe emotional disabilities. In part this impreciseness is due to the lack of a common definition for seriously emotionally disturbed children. What is more, these children may receive services from any one of a number of systems including child welfare, juvenile justice, education, or mental health. The reported number of disturbed children and adolescents in the United States ranges from five to 26 out of 100,000 persons (Brandenburg, Friedman, & Silver, 1987; Knitzer, 1982; "Program Update," 1986).

Consequences of the Problem

The impact of severe emotional disturbance upon youth is devastating. For many of them normal emotional and psychological development is a luxury they will never experience. The impact of the combination of their own behaviors and the stigmatizing labels assigned to them by the mental health system often prevents establishment of healthy peer networks. Without assistance few of these individuals are able to cope in the public school system and thus miss out on many normal socialization activities. What is more, their academic potential is infrequently realized, in part, due to the recurring interruptions in their schooling. These adolescents experience multiple hospitalizations in both acute and long term facilities. Regardless of the treatment benefits such institutionalizations may afford, these experiences result in further stigmatization. Consequently, the adolescent is likely to become even more isolated from peers and community.

The consequences of severe emotional disabilities do not stop with the individual experiencing the problem. Among the stresses experienced by caregivers of youth with emotional disabilities are:

- additional financial costs
- stigma
- difficulty with physical management
- interruptions of sleep
- social isolation
- limitations of recreational activities
- interruption of work and social routines
- feeling pessimistic about the future (Maroney, 1981; Thompson & Doll, 1982; Welles, 1982).

The demands of caring for these youth are extensive. Caregiving demands frequently result in

absence from work. Relationships are torn apart by guilt, anxiety, and the inevitable inequities which these caregiving demands entail. Regardless of how much care the family itself is able to provide, the financial expense of care for the adolescent with emotional disturbance is oppressive. Such expenses may preclude the enjoyment of normal recreational activities or other respite for the family, further escalating their problems. These stresses may result in inadequate attention to other family members and, all too frequently, separation or divorce.

Emotional disabilities affect not only the youth and their family but all of us. Sooner or later, as the family exhausts its financial resources, the public will begin to pay the price of treatment for the emotionally disabled child. Hospitalization, the most radical and costly alternative, is too often the only available option. In Kansas, the per day cost of hospitalizing an emotionally disturbed adolescent is approximately $120.00. Given that figure, it is estimated that the taxpayers expend $7,320 per day, and close to $3,000,000 per year, to provide the average daily census of sixty-one young persons treatment in the adolescent unit at Topeka State Hospital alone.

Many of these families prevail upon the services of community mental health centers and other such providers for individual and family therapy services. These forms of treatment are often needed and beneficial to the family. However, by themselves they are inadequate to meet the needs of the disturbed child who experiences conflicts in all areas of their environment. Therapists thus find themselves providing a "band-aid" response and valuable community resources are misappropriated. Formal services can be helpful but the caregivers' needs go far beyond therapy. They include:

- practical management information
- information about the child's disability
- occasional respite for caregiving
- assistance in locating and using needed resources
- understanding and support.

Mental health is not the only component of the community's social service system to be over burdened by the needs of emotionally disturbed children. The public school is often the first institution to experience the demands and stress of meeting the needs of the emotionally disturbed child. Teachers lacking specialized training are intimidated and frustrated by these children. Precious educational resources are wasted as both the non-disturbed and the emotionally disabled child fail to receive appropriate attention due to the demands of caring for the latter.

The loss of productivity from the distracted and over burdened family caregiver is another disturbing outcome of this problem. Parents are forced to miss work due to caregiving demands and fatigue. On an even more somber note, some of these youth will later become a threat to society by violating the law and require incarceration--a negative spiral in which the significant financial consequences are the least troublesome aspect.

UNIT 2
THEORY OF INTERVENTION

Description

This unit provides an explanation of the theory of intervention upon which the Family Advocacy Model is built. The key principle of building upon family strengths, as opposed to the traditional approach of emphasizing problems, is described. The critical role which advocacy plays in the intervention model is described.

Objectives

1. Be able to list the six principles of the strengths approach.
2. Explain the role of advocate and its importance in the Family Advocacy Model.

Activities

1. As a group the trainees should discuss differences between the strengths approach and traditional mental health intervention.
2. The trainees should be asked to discuss the role of advocacy and how it can be implemented in the field.

UNIT 2
THEORY OF INTERVENTION

Introduction

The emphasis placed here upon the important role which families play in caring for children with emotional disabilities is more than a value statement: it is a reflection of reality. Families care for more disabled children than do other institutions (Lourie, 1978). The main burden of care of a disabled child rests not with professionals but with the child's parents, usually with the mother (Hobbs, 1975). The preponderant share of caregiving responsibilities provided by the family, as compared to even the most intensive treatment the state has to offer, is made clear in the following illustration. The average length of stay at a major mental hospital for an adolescent patient is 273 days. That length of stay in the state's care accounts for only six percent of a 13-year-old's life time, leaving the family with caregiving responsibilities for the remaining 96% of the young person's life. While it is the family who should be the primary caregiver they should also be given the support to fulfill that role (Lourie & Katz-Leavey, 1987). If one thinks in terms of service provision, the family is the prototypical case manager for their child. It is likely that far more disabled people are cared for by their families than by all formal case management systems (Miller, 1985).

The important role which the family plays in the growth and development of the child is well documented (Paul & Porter, 1981; Viorst, 1986; Burr, 1985). The family should play a similarly critical role in treatment planning and decision making for the child with an emotional disability. The family's cooperation and participation is a major factor in the long and short-term success of any treatment plan (Hobbs, 1975). The family is the primary link between the continuum of services which the child or adolescent will need (Lourie & Katz-Leavy, 1987).

A basic tenet of the Family Advocacy model is that it is not beneficial to blame families caring for youth with severe emotional disabilities for their predicament. This case management model views the child's emotional disturbance as a disability. As with many disabilities, its duration may be a lifetime. While there is always the potential that the disability will manifest itself, it is possible to reduce the frequency, duration, and intensity of its recurrence. The emotionally disabled person's environment plays a critical role in determining the extent to which the individual can successfully cope with the disability. Maximizing the beneficial role which the environment can play in the care of adolescents with emotional disabilities is the linchpin for the intervention proposed here.

The ideal intervention for emotionally disturbed children and adolescents would be based upon a complete continuum of care in the youth's community. Such a continuum would include the complete range of services needed by the disabled youth and his/her family. Some of these services would include:

- 24 hour crisis intervention
- short term hospitalization
- specialized and supportive educational settings
- parent support groups
- adequate medical care

- individual and family therapy

- recreational opportunities for the entire family

- respite care.

Furthermore, the service continuum would be integrated and coordinated so as to insure accessibility and efficiency. Service integration and coordination are important because each system has its own eligibility, intake, and case planning standards. Essential to an adequate continuum of care would be financial support for the family so that emotional crisis do not inevitably portend financial ones. Unfortunately, in most communities such an ideal range of services is not available to even the wealthy, let alone the family with average or minimal income.

The goal of the Family Advocacy Case Management model is to assist caregivers to keep youth with emotional disabilities in the most normal environments possible. In most cases, the youth will need the support of family for this goal to be realized.

Building On Family Strengths

Some service providers would argue that family members should not, or cannot, be actively involved in the care of their child with an emotional disability. Cases are singled out in which the family seems unconcerned or "resistant" to involvement in the child's treatment. Such conclusions are understandable if the treatment approach used to work with the family views them as "sick" or as having failed in some moral obligation. Such myths readily perpetuate themselves. A provider's belief that a family is to blame for the child's problem is transmitted to them, intentionally or not. Whether or not such a message is subtle or overt it's likely that the caregivers would then hesitate to become involved. This natural response to feeling unwanted is in turn interpreted by professionals as "resistance." As a consequence, less and less energy is devoted by treatment providers to involving the parents. As the barriers to cooperation emerge, the distance between all parties becomes greater with the child and his family being the ultimate losers.

The reality is that most families simply are not used to being actively involved in their child's treatment. They are not used to having their needs be a concern of professionals. They are not used to being asked what they think is best for their child and having their answers listened to. They are not accustomed to being treated as primary service providers for their child's care. The acquisition of these roles requires training, practice, and support. The provision of that support is central to the strengths approach. Until that support has been diligently delivered no family member should be labeled "unworkable."

Principles of the Strengths Approach

The helping model proposed here for working with families caring for children with emotional disabilities is a strengths approach. This approach incorporates the following principles:

1. An active role by the family caregivers is essential for enabling the child to live in a normal environment.

2. Society should accommodate the needs of families who care for children with emotional disabilities.

3. Caregivers themselves are the best informants regarding their own needs and the

needs of their child.

4. Family caregivers have strengths.

The strengths approach takes the best of what casework has to offer and applies it to the special needs of family caregivers. Application of the strengths approach requires the worker to get at the central core of the tasks which the family faces in caring for their child and to help the family caregivers perform their tasks with less emotional burden. In the strengths approach the primary goal is to help the family acquire the resources needed to care for their child. Enabling, which entails "helping a person to mobilize his own drives and abilities for use in a desired direction" (Perlman, 1957, p. 197) is an essential skill for implementing the strengths approach.

Children with emotional disabilities and their families are all different. They are people who have aspirations, goals, and strengths that need to be developed and talents that need to be expressed, as well as problems for which they need help (Rapp & Chamberlain, 1985). "The vast majority of families with disabled members are no more dysfunctional in their interactional system than any other family" (Turnbull, Summers, & Brotherson, 1983, p. 43). However, use of the strengths approach does not justify a denial of the client's problems; it is important that they be identified and understood. The strengths approach requires that the strengths of the family and the youth be even more zealously assessed than their weaknesses and their strengths become the means for ameliorating their problems.

While the case of Sarah and Frances is fictitious, results similar to those noted in the examples below have been achieved with the strengths approach. The case examples are used to demonstrate the six principles of the strengths approach.

An active role by the family caregivers is essential for enabling the child to live in a normal environment

The importance of an active role by the family in the treatment of a child with an emotional disability is a given in the strengths approach.

> Thirteen year old Sarah was hospitalized nine months ago due to her obedience to the voices which were telling her to set fires. Her mother, Frances, has been kept closely informed of Sarah's progress. Hospital staff have been careful to explain the process of treatment to her mother in straightforward language. A worker, who was assigned to Sarah's family upon her admission, began working towards the adolescent's return to the community. Frances was expected from the outset to play a major role in planning and preparing for her daughter's return home.

While the extent of a caregiver's involvement in their child's treatment will differ for each family, insuring that involvement to the greatest extent possible is a priority in the strengths approach. At the outset of service provision the assumption should be that the family caregivers can and will be fully involved in their child's treatment until facts and experience prove that they are unwilling or unable of doing so.

Society should accommodate the needs of families who care for children with emotional disabilities

There are many reasons that society should be expected to accommodate the needs of families who care for children with emotional disabilities. Parents have every right to expect that the community will be responsive to their child's special needs. Not only can the case be made that children belong with their parents on emotional, moral, and legal grounds, but it's also just a plain

good investment. The community could not provide as economically as the family the many years of supervision, guidance, nurturing, and physical care that children require. The 24 hour supervision, alone, which parents provide to their children costs the state a fortune to duplicate.

In keeping with the philosophy of accommodation the entire community is looked upon as a potential resource to meet the needs of the youth and family caregivers in the strengths approach. For those services which exist but are not accessible to the family due to political or policy problems bridges must be built to ease access.

> It was the worker's job to intervene on behalf of the family when the state social service department, the hospital, and public school were not coordinating to prepare for Sarah's return to the community.
>
> When it was learned that a major impediment to Sarah's return home was the lack of respite care to give her mother an occasional break, the worker began meeting with local agencies to develop such a service.

In the strengths approach the service provider must place a major emphasis upon empowering the family members themselves to care for their child. This empowerment may include training the caregivers in the skills of assessment, prioritizing, time management, advocacy, service networking, and resource acquisition.

> The worker helped Frances to avoid feeling so overwhelmed by her caregiving demands by first making a list of all she needed to do, prioritizing it, and then devising a plan of action.

Caregivers themselves are the best informants regarding their own needs and the needs of their child

In the strengths approach the family caregivers are considered to be the best informants of their own needs. Unlike other models of helping, workers applying the strengths approach are careful to not impose their view of the world upon the family's situation. The safeguard used to insure that the caregivers will be actively involved in determining how their needs will be met is a simple though rarely applied technique: they are asked. Goal setting, which is a proven means for involving caregivers in identifying their family's needs, is an important technique in the strengths approach (Houts & Scott, 1975; Malucchio, 1981).

> From the outset the worker was deliberate and consistent in asking Frances what she thought were her family's needs. With the worker's help the identified needs were formulated into achievable goals. These goals then became the focus of the worker's activities. Goals were never imposed upon the parent by the worker but instead were mutually agreed upon. The tasks for goal achievement were shared by Frances and the worker and responsibilities for their completion were clearly delineated. While the worker does not hesitate to suggest or clarify a perceived need, ultimately it is the parent who determines the goals.

Family caregivers have strengths

Too often the parents of youths with emotional problems are blamed for the child's difficulties. These caregivers may indeed appear especially harried due to their attempts to singlehandedly meet the youths needs. It behooves the case manager to remember that these caregivers have many strengths, talents, and abilities. The worker's assessment of these strengths should be ongoing and every opportunity to help the caregiver acknowledge them should be taken advantage of.

Frances was feeling discouraged and blamed herself because Sarah was expelled from school for two days due to behavior problems. The case manager acknowledged the parent's disappointment and then reminded her that such a problem had not occurred in the previous three months, whereas as it had been quite frequent. Frances' role in that progress was reviewed. With a new perspective the parent and worker were able to talk about a plan with Sarah to avoid more problems at school.

Conclusion

The role of the family caregiver is essential if the child with an emotional disability is to live in a normal environment. But the demands of such caregiving are imposing. Traditional intervention models too often do not adequately support the family's caregiving role. The strengths approach provides an alternative which treats the family as indispensable to the child's care.

While the family is the most important resource for enabling a child with an emotional disability to live in a normal environment, the responsibility for the youth's care also belongs to the community. Social service providers must learn what families need to care for their child with an emotional disability, remove the barriers which prevent them from receiving needed services, and build bridges so that the family can access services when needed. The strengths approach provides a method of helping which is conducive to these tasks and to empowering the family in their caregiving role.

Advocacy: The Critical Case Management Function

The worker's role as advocate deserves special attention since it is so integral to the effective implementation of the model. Webster's defines advocate in two ways. On the one hand, he/she is "one that pleads the cause of another." Another definition describes the advocate as "one who argues for, defends, maintains, or recommends a cause or a proposal." Both meanings of advocacy have been employed in the social work literature. The advocate role has been an important thread running throughout social work's history (NASW, 1979).

The worker may need to assume the role of advocate on behalf of the individual client or on the systems level. Advocacy, in the form of informal interpersonal negotiation, may serve to remove barriers which prevent a client from receiving entitlements or other needed services. At times, simply making service providers aware of barriers to client utilization of services may lead to an improvement of the situation. However, more stringent measures may need to be taken by the family advocate including enlisting the support of supervisory or administrative level staff within their own agency or even to make use of more formal channels (e.g., State Protection and Advocacy Office) to advocate for clients (Intagliata, 1982).

As the family advocate works with the family caring for a child with emotional disabilities it is inevitable that gaps in the service system will be identified. The advocate may discover that the community is even lacking some the basic services which the family needs. The role of the family advocate in such situations is, at a minimum, to document the gap and make their supervisors aware of the situation. Direct action by the family advocate includes documenting the need for the missing services and informing other key actors in the community of the service gaps (Intagliata, 1982).

UNIT 3
UNDERSTANDING THE FAMILY'S ROLE

Description

This unit is designed to help the trainee understand and appreciate the family's important role in caring for youth with emotional disabilities. The demands placed upon families by caregiving are discussed first. They are followed by a discussion of the most common needs expressed by family caregivers.

Objectives

1. The trainees will be able to explain why the role of family caregivers is so critical if youth with emotional disabilities are to live in the least restrictive environments.

2. List some of the many demands, and their consequences, placed upon family caregivers.

3. Describe the type of services found to be most helpful to families caring for youth with emotional disabilities.

Activities

1. Have the trainees describe the demands of "normal" parenting then add to that list the additional extraordinary demands of caring for a child with an emotional disability.

2. Have the trainees discuss which needs of the family caregiver are least likely to be addressed by traditional mental health interventions.

3. Arrange to have a parent who cares for a youth with an emotional disability speak to the group.

UNIT 3
UNDERSTANDING THE FAMILY'S ROLE

Demands of Caregiving

In the past, the primary attention received by families caring for children with emotional disabilities has been in regards to their supposed role in the development or maintenance of their child's problems. While this blaming posture has lessened somewhat over time (Paul & Porter, 1981) there has been far less concern devoted to the impact of the child's illness upon the family (Holden & Lewine, 1982). Sontag (cited in Drotar & Bush, 1985) asserts that every chronic illness presents a complex set of interrelated stresses. "The entire family is shouldering a burden because one of its members is mentally ill" (Kreisman & Joy, 1974, p. 47). Drotar and Bush (1985) contend that "the presence of a chronically ill child exerts a powerful influence on family life, parental self-esteem, and the mental health of each family member" (p. 521).

The parents of the child with an emotional disability must deal with the same feelings of guilt, failure, self-doubt, resentment and anger as do all parents "while simultaneously coping with the excessive demands imposed on them by their child who has special needs" (Paul & Porter, 1981, p. 58). A child's chronic illness engraves a family's life with worry (Hobbs, Perrin, & Ireys, 1985). "There is ample evidence that the adjustments required to deal with the behaviors and to provide care to the emotionally disturbed child "create a severe and chronic level of frustration and tension in the family" (Holden & Lewine, 1982).

The number of different types of stress experienced by caregivers of youth with emotional disabilities is consideraole. Those reported in the literature include:

- additional financial costs
- negative social stigma
- difficulty with physical management of the youth
- interruptions of sleep
- social isolation
- limitations in recreational activities
- interruption of normal routines
- feeling pessimistic about the future (Moroney, 1981; Thompson & Doll, 1982).

For those families who can afford insurance, many policies provide only minimum mental health coverage. But even the best of coverage eventually runs out and not even well-to-do families can handle frequent hospitalizations at exorbitant rates (Willis, 1982). It's difficult for anyone who has not parented a child with a severe emotional disability to fully appreciate the demands of caregiving. Overlaid upon the very real practical demands, such as time, energy, and money, are the emotional costs. Self-doubts, such as "are we doing enough," and guilt due to the understandable resentment for the price being paid to care for the special child are only two example of the emotional toll. The worker can significantly help the caregiver deal with these demands by acknowledging the caregiver's indispensable role in caregiving and accepting the parents' doubts and fears without judging.

Several studies speak of the constant worry and anxiety experienced by these caregivers. Additionally, they must often cope with feelings of guilt for having negative feelings about their child (Paul & Porter, 1981). Neither are siblings immune to the stress entailed in caregiving to the emotionally disturbed child. The disproportionate time given to the disturbed youngster may exacerbate the rivalrous feelings normally experienced by children (Marcus, 1977).

Hatfield's 1978 study of how caregivers were affected by their relatives's illness found that, overall, "a picture emerged of unremittingly disturbed family life marked by almost constant stress" (p. 358). The same study determined that a marital relationship may suffer equally as much from the stress of a mental illness in the family as is the case with a physical ailment. Thompson and Doll's 1982 study of 125 family caregivers found that 62% of the families reported feeling moderate burden and 15% severe as a result of caring for the mentally ill member. Thompson and Doll concluded that these families have been placed in an emotionally demanding, often untenable situation and that there is evidence for the "universality" of these emotional burdens across social class and race.

From their study of 56 parents of psychiatric patients Polasznik and Nelson (1984) report that the nature of the stress that is experienced by the families of the mentally ill is multifaceted. These stresses included disruption of social and day-to-day living routines and missed work due to caregiving responsibilities. Doll (1976) interviewed "significant others" of 125 recently released mental patients. The respondents reported strong feelings of pain, bitterness, and of being trapped. Sympathy was mixed with anger, frustration with resignation. Willis (1982) reports that a common problem among family members is the feeling of being tied down and not able to live one's own life. "Families of a chronic mentally ill person find it difficult to travel or to maintain much of a social life" (p. 619).

In a study undertaken by Holden and Lewine (1982) 143 families with emotionally disturbed members were queried as to the stresses they experienced. Among the most frequently cited were:

- worry about the patient (80%)
- finding effective treatment (80%)
- disruption of family life (76%)
- financial problems (61%)
- increased tensions (74%)
- financially affected (74%)
- major family disruption such as divorce (25%).

It is one thing to contend that children with emotional disabilities belong with their families but service providers need to keep in mind that providing such care entails extraordinary demands. No family caregiver can, nor should they be expected to, provide the total care which a youth with severe emotional disabilities requires. "Families must be helped to help exceptional children grow up successfully and live lives as normal and self-fulfilling as possible" (Hobbs, 1975, p. 223).

If the goal of helping children and adolescents with emotional disabilities live successfully in normal environments is to be realized their families must play an integral role

in their treatment (Turnbull, et. al., 1983). Too frequently, the family members have been either ignored or blamed for their child's disability. These children will need multiple formal services from the community but the role of their families must not be neglected in the process of providing these services. Family Advocacy Case Management provides a method for maintaining the family's central caregiving role while connecting them to community resources.

Caregivers' Needs

A review of the literature suggests that the needs of families who care for children with emotional disabilities fall into the general categories of educational, psychological, financial, and social support (Pless & Perrin, 1985). Platman (1983) summarized the results of several studies which explored the needs of families with relatives labeled as schizophrenic, a not uncommon diagnosis given to children with emotional disabilities. The following are among the needs of families caring for relatives with emotional disturbances:

- information about the illness and the potential effectiveness of treatment;
- information about practical management techniques;
- a desire for consistent treatment for their relative;
- an arbitrator to negotiate between differing professional opinions;
- assurance that the relative will receive treatment when his/her behavior is too disruptive to maintain at home;
- people to talk to who understand what they are going through;
- temporary substitute care;
- help to access community resources (Platman, 1983; "Problems For," 1977; Creer and Living, cited in Platman, 1983; Hatfield, 1978; Lynch & Kruzich, 1986).

A common theme emerging from the literature is the practical nature of the needs of families who care for emotionally disturbed relatives. The caregivers desire straight forward accurate information regarding reasonable expectations, specific suggestions for managing disturbing behaviors, and help in accessing community resources.

A family advocate can be a tremendous help to a family just by providing accurate and understandable information about their child's needs. Parents are often intimidated by mental health professionals in formal office settings and thus fail to ask basic questions. A case manager who gives a family member "permission" to express fears, guilt, and anxiety about their child's disability can provide them much relief. Once those anxieties are expressed the family can make use of objective information from other service providers.

It is important for helping professionals to keep in mind that these parents are "already sorely tested by their children's difficulties and need less talk about double binds and the ideal intensive therapeutic milieu somewhere, sometime, and more direct day-to-day assistance" both for their troubled child and for themselves as primary caregivers ("Problems For," 1977, p. 356).

Children with emotional problems need the guidance and support of their families if they are to live successfully in the community. The demands placed upon the family from this type of caregiving are severe and extensive. Effectively meeting these diverse caregiver needs requires a

different type of professional response. One that goes beyond the traditional therapist's role. What is called for are professional relationships which include the family and the youth with an emotional disability. The family and the troubled child must be considered part of the treatment team and assisted to understand the nature of the disability and its prognosis and treatment (Hatfield, 1978).

UNIT 4
THE CAREGIVER-FAMILY ADVOCATE PARTNERSHIP

Description

This unit describes the essential elements of an effective working relationship between the family advocate and family caregiver. The importance of and essential elements in a working relationship are listed. Specific expectations of the worker and caregivers are explained. The affective component of the relationship is discussed. Actual behaviors used by the family advocate when engaged in the helping process are described.

Objectives

1. **Describe the importance of establishing a positive working relationship with the family caregivers.**
2. List the indicators of a positive helping relationship.
3. Describe the steps for building a positive helping relationship.
4. List the expectations of the family advocate.
5. List the expectations of the family caregivers.
6. Describe the typical affective reactions of the worker and the family caregivers.
7. Identify strategies for coping positively with the affective component of the helping process.
8. List the actual behaviors of the family advocate.

Activities

1. Brainstorm ways in which the relationship building process can be initiated without threatening the client.
2. List the reasons it is important for both the family advocate and caregiver to be clear about their mutual expectations.
3. Discuss the emotions likely to be encountered by the family advocate and strategies for coping with them.
4. List the emotions likely to be experienced by the family caregivers. Discuss ways in which the worker can be most helpful to the family member.
5. Using a case example, role play implementation of actual worker behaviors.

UNIT 4

THE CAREGIVER-FAMILY ADVOCATE PARTNERSHIP

The Importance of Relationship

A partnership with parents of adolescents with emotional problems must be built by the family advocate. The family advocate must gain an appreciation for what these families have experienced and understand what it is like to live with a child who has emotional problems. The family advocate must recognize the struggles and pain these people experience as well as their resilience, flexibility, endurance and courage. The family advocate must provide accurate information, emotional support and acknowledge that each family member has his/her own needs. The family advocate must admit the limits of his/her knowledge and of the current unclear understanding of mental illness. Both the parents and the family advocate must learn from each other. These attitudes and positive working relationship can be achieved when the family advocate:

1. Treats parents with dignity and respect;

2. Builds a relationship based on honesty and mutual understanding;

3. Acknowledges the expertise that parents have about their child and respond to their stated needs;

4. Takes time to learn about the family's previous experience with mental health professionals (i.e., how were they helpful, what problems did they cause the family, how do family members feel about involvement of professionals, etc.).

5. Works collaboratively with parents in defining the problems and in the decisions about possible solutions.

6. Takes advantage of every opportunity to point out the family's strengths.

7. Acknowledges and compliments the parents for both small and large efforts on behalf of their family.

Case management with adolescents and their families will only be effective if the family advocate listens in a non-judgmental way to the youth and their parents. A certain level of informality has to be established to break down the barriers of the family's perception of the family advocacy role and will only be accomplished when the family advocate is seen by the family as truly an ally. The process of building a partnership takes time and has to be paced by the family. When the family interacts with the family advocate in a comfortable way and shares with them the other aspects of their lives the family advocate will know that the partnership has been accomplished. For example, when a mother needed a pilot light lit and the family advocate was able to show her how to do it, or when a mother needed some bookshelves moved and the family advocate was able to assist in getting them moved for her. Another way the family advocate will know that they have built a partnership with parents is when the family advocate can sit around the kitchen table drinking coffee with the youth's parents and talk about what is going on with them, the way adults might talk in a social situation.

Accessing the youth's and family's strengths and seeing them as resources will make the family advocacy relationship successful and gratifying for all involved. Once a partnership is

developed the establishment of goals and objectives will be easier and the youth and their family will increase their confidence in being able to meet the challenges they face.

The following is a list of guidelines that may be useful in initial contacts with adolescents and their families:

- Set up the initial contact to be in their home or in a neutral setting.
- Be pleasant and friendly.

- Actively listen to what they have to say and what they are feeling.

- Maintain as much eye contact as possible.

- Respect the youth and their family and treat them in the way you would like to be treated.

- Move into the assessment after the family has gotten to know you and the interaction feels comfortable. This may take a few hours or a couple of months.

- In dealing with any items that may be awkward or embarrassing, maintain a matter-of-fact composure.

- Keep the meeting informal and the interview semi-conversational.

- At times a youth or family may tend to ramble or over-elaborate. If it becomes disruptive to the assessment focus on the tasks at hand without cutting them off.

- Be prepared to explain meanings of words and rephrase questions.

Expectations of Case Managers and Caregivers

The heart of the family advocacy process is the relationship which is developed between the family advocate and the family caregiver. Mutual trust and respect are among the characteristics which must be present in the relationship if the goal of keeping the adolescent in the community is to be attained. All helping relationships are unique and complex and must be allowed to unfold at their own pace and form. However, it is important that reasonable expectations in the helping transaction be established and clearly communicated. Expectations for both the family advocate and the caregiver are listed below.

Expectations of the Case Manager

- the purpose and goals of the program will be explained during the initial contact and restated as needed;

- the caregiver will be valued as the expert on their child;

- the child will be considered an expert regarding their own needs;- the family advocate will help the parent identify and obtain needed resources;

- the family advocate will provide information to help the parent understand and manage their child's behavior;

- the parent will be provided support and information to help them cope with their extraordinary caregiver demands;

- the caregiver will be treated as an equal;

- conversations will remain confidential;

- the parents' privacy will be respected;

- contacts will be arranged in advance and at the parent's convenience whenever possible;

- the parent will be provided frequent opportunities to give feedback as to the program's effectiveness.

- whenever possible the family advocacy process will be carried out in a setting which is most comfortable for the caregivers; ideally, the family's home.

The Case Manager's Expectations of the Parent

- the family advocate will be provided reasonable opportunities to meet with the parent;

- the parent will not be in an altered state of mind due to substance abuse during contacts;

- the parent will make a reasonable attempt to notify the family advocate if an appointment needs to be canceled;

- following the establishment of an appropriate relationship, the parent will become involved in the objective achievement process;

- the parent will participate in program evaluation efforts.

It is the responsibility of the family advocate to communicate the above expectations. This communication task is an on-going process. The family advocates must determine the appropriate time for communicating, clarifying, or reiterating the expectations.

Affective Involvement

It is expected that the family advocate and caregiver will become involved in a meaningful human relationship. Given the wide range of human emotions that process entails, there is no way that all of the feelings which may be encountered can be inventoried. However, the emotions most likely to be expressed by the caregivers are listed in the table below along with suggested family advocate responses. The table is followed by an elaboration of the affective component of the family advocacy process.

CAREGIVER EMOTION	SUGGESTED CM RESPONSE
Suspicion of the worker	Be patient. Acknowledge the parent's right to be cautious. Clarify role and purpose through explanation and specific suggestions for action.
Denial of their child's problems	Do not confront, initially. Ask for specifics about how child is doing is the seven Life Domains. Offer to provide accurate info. about child's strengths and needs.
Anger toward "the system"	Acknowledge feelings. Distinguish case manager's role through action. Offer to advocate for family with other providers.
Ambivalence about child's return home	Acknowledge feelings. Ask parent to describe the demands of caregiving. Reflect back. Set goals to plug gaps in caregiving needs.
Resentful of the case manager's relationship with the youth	Acknowledge that the parent as knowing the youth better than anyone else. Be careful to inform the parent of all meetings with the youth. Ask the parent's opinions frequently about their child's needs and progress.
Sadness (or anger, withdrawal, etc.) at time of termination	Begin preparation for termination at the outset. Express your own sadness about ending the relationship. Organize some type of "ending ceremony."

The family advocate is expected to treat the parent with respect and courtesy. Acknowledging and affirming whatever the emotions which the parent experiences is a significant aspect of that responsibility.

Any parent of a child with a disability is likely to feel intense emotions regarding their child's problems. These emotions may include:

- denial
- anger
- resentment
- ambivalence
- intense desire to help
- love
- joy

The family advocate needs to provide the opportunity and "permission" for these feelings to be expressed. The parent must not be judged because of them.

When the parent gives indications of being emotionally ready for such assistance, the family advocate can provide accurate information regarding the child's problems and their management. The parent may also benefit from help to get involved in a support group with other parents confronting similar problems.

At the outset of the relationship, the parent may be cautious or even suspicious of the family advocate's intent. It is likely that the parent by this time has encountered many professional helpers who "know what's best for their family." The family advocate must respect this hesitancy and be patient but persistent in establishing a relationship. Actions, more than words, will be proof that the family advocate is on the family's side.

Many caregivers of children with emotional disabilities are not accustomed to being asked their child's needs, much less being fully involved in goal setting for the provision of services. Consequently, at the outset the caregiver may need to be convinced that the family advocate really does want them fully involved. This "convincing" can best be accomplished through gentle persistence by consistently setting the expectation, in a variety of ways, that the caregiver will be fully involved.

As the relationship between the family advocate and the adolescent grows, some parents may feel threatened by their child's emotional bond with this "stranger." Consequently, the parent may distance him/herself and shut the family advocate out. The parent should be reassured through a variety of means that he/she is considered the expert in their child's care and that there is no intention to undermine the parent's role.

The family advocate must be careful not to give the impression that the parent is being blamed for their child's problems, especially since many service providers continue to express such biases despite growing research evidence to the contrary. This can be accomplished by clearly acknowledging the parent's unique and all important role in their child's life. Also, The provision of clear, accurate, and understandable information regarding their child's disability can do much to reduce anxiety and make the problems manageable.

It is important that the family advocate acknowledge and accept that he/she is not emotionless. Intense feelings will be experienced by any helper involved with another human being, especially families with multiple and serious concerns. Among the feelings which the family advocate can expect to experience are:

- confusion
- being overwhelmed
- frustration
- anger
- caring
- sadness
- joy

After acknowledging and accepting the intense emotions experienced as part of the helping process, the next step for a healthy response is to share them with a colleague or supervisor. Because of the inadequate number of formal services and the lack of coordination among existing ones in most communities, the case manager can easily become overwhelmed and discouraged. It is

important to maintain perspective and remember that no one person can make up for what should be a total community response. It is important that family advocates express their frustrations with their supervisor and colleagues. Group supervision sessions are an excellent opportunity to learn that one is not alone in their frustrations and to regain perspective.

In some cases it is appropriate for the family advocate to share their feelings with the parent. Before doing so the family advocate is advised to "step back" from the situation and ask two questions: First, what is the source of this feeling? Is it really something the parent did or does it "hook" a personal value? Second, is it to the parents benefit to hear me express it? Can he/she grow from the experience or am I only adding a burden? Of course, the parents of children with emotional disabilities, like all of us, enjoy genuine expressions of affection and compliments.

It is normal and predictable that the family advocate will become very fond of the adolescent and his/her family member. Naturally, this attachment will lead to discomfort when the inevitable termination time approaches. It is important that the family advocate acknowledge the feelings of sadness and loss, request assistance from supervisor or colleagues, and begin preparing the family members for termination from the outset of the relationship. This preparation can be accomplished, in part, by reminding the parent of the time limited nature of the work. At the actual point of termination each person should be allowed an opportunity to grieve their loss. A final party or exchange of gifts are examples of how this can be accomplished. If the family advocate has been successful in their work, the parent will have developed additional sources of support to fill the void left by the family advocate's absence.

Actual Behaviors of the Family Advocate During the Early Stages of Work with the Family

The contacts most important to the success of Family Advocacy Case Management will take place in the caregiver's home. For this reason, the family advocate's ideal behavior during one of those contacts will be described here. The description is intended to serve as a model for those contacts though it is emphasized that each contact will be unique depending upon the individuals involved, the setting, time, etc.

The family advocate's first responsibility is to establish a working relationship with the caregiver. Such a relationship implies mutual respect, trust, and a sense that the family advocate really can help. As this relationship grows, the focus, affect, and content of these meetings will change, sometimes dramatically. For example, during the first several meetings with the parents the family advocate can expect them to be cautious and hesitant to become involved. They may not do much of the talking since they are trying to figure out "where you're coming from." These early meetings may seem quite formal and the content superficial. After a positive working relationship is established a definite change will be noted. The parent may initiate the conversation and even the contacts themselves. Meetings will be less formal, perhaps taking place in the kitchen instead of the family's living room.

As is the case in most helping relationships, the bulk of the work is accomplished during the middle phase. In the context of this program the middle phase is said to occur after the relationship has been well established (e.g., approximately 60-90 days following the initial contact). For this reason this description depicts a middle phase session.

Description of the Family Advocate's Behavior

It is expected that the family advocate will have set the date and time for the session with the parent's approval. The family advocate will arrive on time, or call to say that there has been an unavoidable delay. Upon arrival the family advocate will announce his/her presence and wait for permission to enter. Common courtesies should be extended to all family members present.

As in any informal social contact, the family advocate should initiate normal social courtesies (e.g., inquire as to the family member's health, recent events, etc.). It is expected that the family advocate will come with a prepared agenda for the meeting. The parent should be made aware of what the family advocate intends to accomplish. The family advocate will check with the parent to learn if he/she has additional or more pressing items for discussion.

Each individual present who has a legitimate role to play in the session should be given the opportunity to participate. This may require assertive behavior on the family advocate's part such as asking the person a direct question. The family advocate is expected to take appropriate action if any one person monopolizes the conversation. These actions could include asking for the opinions of others, praising the reluctant participant for their contribution and the "monopolizer" for listening. The conversation should be kept on focus through a variety of techniques including setting the agenda at the outset, praising participants for what is accomplished, and reminding those present of the meeting's purpose.

In the event that distractions occur which interfere with a productive discussion the family advocate will request that it be removed (e.g., tv or radio too loud). It is also appropriate to request that the meeting be moved to another room if necessary.

During the middle phase of work the contacts with caregivers will be primarily devoted to identification of objectives and strategies to achieve them. Objectives can be initiated by the adolescent, parent, or family advocate. Regardless of who initiates the objective the process must be a mutual one. The objective and strategies will eventually be recorded in written form and the caregiver's signature affixed.

While written objectives are the tangible outcomes of the program, the most important aspect of family advocacy is the relationship between the worker and caregiver. Therefore, the session should provide many opportunities for expression of humor, caring, and other emotions appropriate to the time and people present.

The session should be kept to a reasonable length so that it does not become an inconvenience for anyone involved. One hour is a reasonable guideline. However, the family advocate must be sensitive to this or other factors which may cause discomfort during the meeting. In the closing phase of the session the family advocate is expected to thank the caregiver for their time and assistance. The next meeting date should be established at that point.

UNIT 5
ASSESSMENT OF FAMILY STRENGTHS AND NEEDS

Description

Unit 5 describes the Life Domains of Family Functioning which are used as a framework for assessing family strengths and needs. The five components of the family strengths and needs assessment package are described along with suggested procedures for their use. Guidelines for the worker to keep in mind when using the tools are also included.

Objectives

1. Name and describe the four components of the Family Systems Framework
2. List and explain the seven Life Domains of Family Functioning.
3. Describe the three purposes for which the family functions may be used.
4. List the five tools used for assessing family strengths and needs.
5. Describe the purpose of each of the tools.
6. Explain how each of the tools are to be used.
7. List the guidelines which will present the tools being used to the detriment of the family.

Activities

1. Using a case example, identify some of the family's strengths and needs in each of the seven family functions.
2. Distribute copies of each of the assessment tools and have the trainees review them.
3. With the trainer assuming the role of family advocate, role play how each assessment tool will be explained to the client.
4. Discuss how information gained from each of the assessment tools can be used by the worker.
5. Discuss procedures for collecting and using the data from the tools for feedback to the program staff.
6. Role play examples of how the guidelines for use of the assessment tools can be implemented with family members.

UNIT 5
ASSESSMENT OF FAMILY STRENGTHS AND NEEDS

The Life Domains of Family Functioning

The family can be thought of as a system whose primary job is to meet the needs of its members (Caplan, 1976; Leslie, 1979). Figure 1 illustrates the family system conceptual framework developed by Turnbull, Summers, & Brotherson (1984). This framework is the primary means used for assessing a family's strengths in the Family Advocacy Model. Each of the four components of the framework are described below with material taken from Turnbull, Summers, & Brotherson (1984).

Family Resources

Family resources are made up of the descriptive elements of the family, including characteristics of family members with special needs (e.g., type, level of severity); characteristics of the family (e.g., number of members and forms, cultural backgrounds, income, geographic locations); and personality characteristics of individual family members (e.g., health, intellectual capacity, and coping styles). From a systems viewpoint, resources can be thought of as the input into family interaction.

Family Interaction

Family interaction refers to the ongoing relationships that occur among family members. These relationships, the process of interaction, are responsive to individual and collective family needs.

Family Life Cycle

Family life cycle represents the sequence of developmental and non-developmental changes that affect families. These changes alter family resources (e.g., a child is born) and family functions (e.g., mother stops working outside the home, which provides more time for child-rearing but less family income). These changes, in turn, influence how the family interacts.

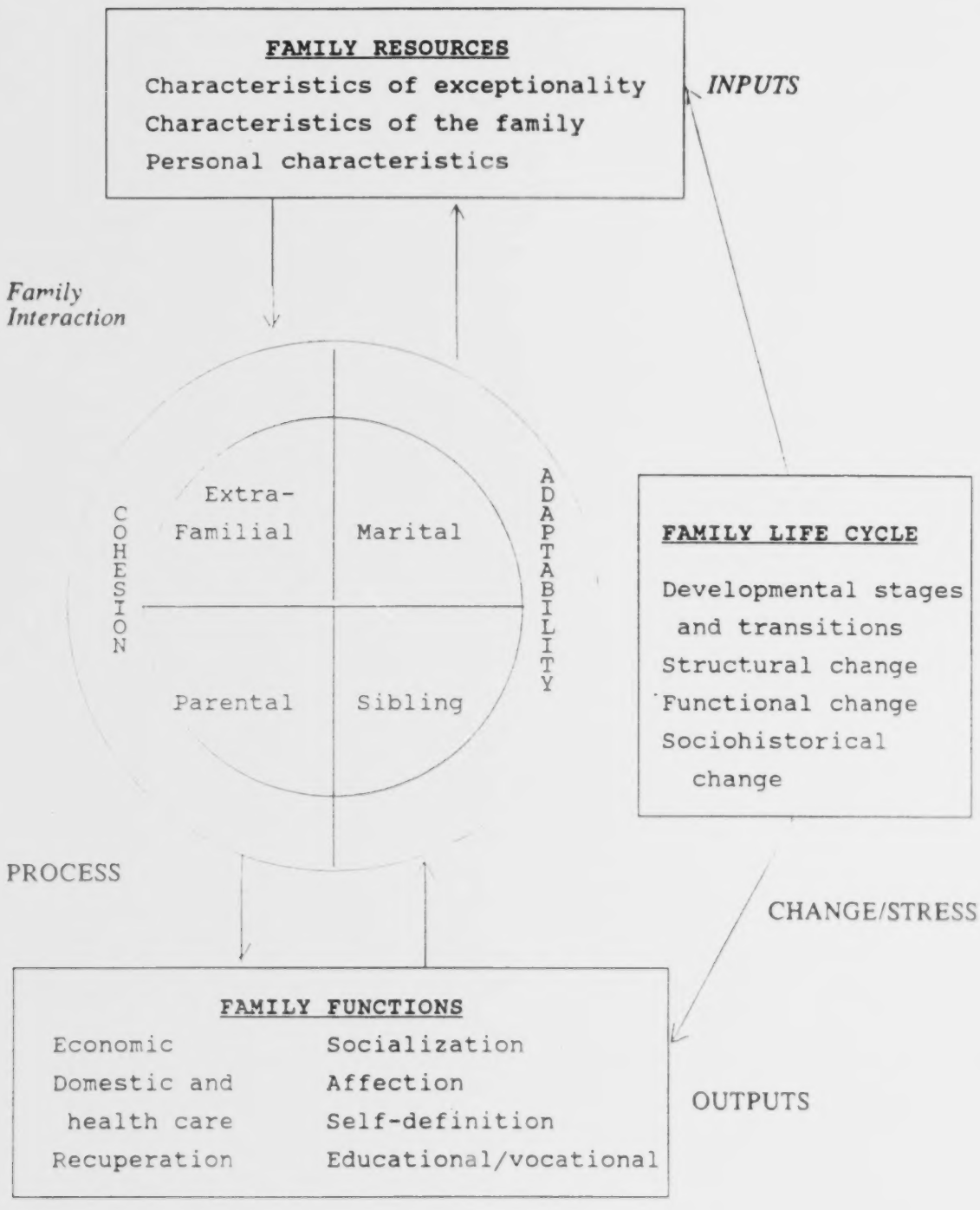
Family Functions

Family functions represent the different categories of needs the family is responsible for addressing. The purpose or output of family interaction is to produce responses to fulfill the needs associated with family functions. Because of the important role they play in assessing family strengths in the Family Advocacy Model the seven family functions are described in more detail below.

The seven family functions or tasks which families must perform to meet their needs are in the domains of:

- Affection
- Education
- Domestic
- Health

FAMILY SYSTEMS CONCEPTUAL FRAMEWORK



Source: Turnbull, A.P., Summers, J.A. , & Brotherson, M.J. (1984). *Working with families with disabled members: A family systems approach*. Lawrence, KS. Kansas University Affiliated Facility, University of Kansas.

- Economic

- Recreation

- Socialization

The seven family functions are described in the following section. A case example is used to illustrate ways that the case manager may use a knowledge of the family functions in the assessment process.

The Seven Family Functions

Affection

Affection tasks of the family include the provision of nurturance and love to its members. The companionship, level of intimacy and expression of emotions also fall into this domain. Do members of the family feel loved? Where do members of the family receive emotional support? Are persons respected? Do parents have authority in the family? Are feelings expressed openly in the family? Do family members feel needed and worthwhile? Such questions as these can be used by the worker to assess the family's ability to meet their affection needs. Both the family's strengths and needs should be identified from the perspective of each of its members.

> After meeting with Mary and her mother, it was clear to the case manager that neither family member felt that their needs for nurturance and affection were being met. Mary had privately commented to the worker that her mother "just did not understand me" and the parent complained that Mary "could care less how I felt." As a way to point out their strengths in this family function (e.g., Mary and her mother had recently had a heart-to-heart talk about a grandparent's terminal illness) and to identify areas for change, the worker both individuals some of the questions related to their family's affectional needs. One outcome of that discussion was an agreement between Mary and her mother to set aside one hour per week when each of them could have equal time to express troublesome or positive feelings.

Education

The family's education function includes assignment of tasks and responsibilities in the home in addition to monitoring and involvement in the formal education experiences of family member. Such questions as, "Are job assignments fair? Do members keep up with their tasks and responsibilities? Do parents communicate with school personnel? Is the youth encouraged to attend school? Is school work important? Does the family provide time and direction for education in school, social situations, and spirituality?" can be used to assess the family's effectiveness in this domain.

> In the process of assessing the family's strengths in the education domain, the worker learned that a source of frustration for the parent was Mary's refusal to help launder the family's clothes. During a joint discussion Mary informed the worker and her mother that she was afraid she would "get yelled at" if she tried to use the clothes washer and caused it to malfunction. An agreement was reached which resulted in the parent, worker, and Mary writing a clear set of instructions which were to be posted in the laundry room. A time was set for the case manager to train Mary in the use of the washer while her mother was at work. Also, an every other week launder schedule was agreed to by Mary and her mother. This arrangement allowed Mary to gain another independent living skill, eliminated one source of family conflict, and avoided an additional demand upon the parent's already demanding schedule.

Domestic

The domestic functions of the family include the basis physical and transportation needs of the family. Does everyone have adequate clothing? Do they feel safe and comfortable in their home? Are the family's nutritional needs met? Is adequate transportation available? These questions are among those which can be used to assess the family's ability to meet its domestic needs.

> The worker noted that Mary frequently complained about the food her mother served at home. The parent had remarked on one occasion that she was concerned both family members were gaining too much weight. An assessment of the family's abilities to meet its domestic needs led to the formulation of several objectives. With the parent's consent, the worker and Mary visited the registered dietitian at the health department to obtain basic information on a healthy diet. The family mutually selected some appealing and simple recipes which the case manager helped Mary to prepare. During their weekly joint meeting the worker helped the family prepare a menu with mutually agreed upon low calorie meals.

Health

This family function includes providing adequate medical and dental care to its members. Do family members have the information they need to take care of themselves? Do family members receive adequate medical and dental care? If a member of the family has a medical regimen to follow is it adhered to?

> On several occasions the worker noticed that the parent had to squint to read written material. Mary had also mentioned to the worker that her mother had lots of headaches. After the worker felt confidence in their working relationship, she asked the parent if she her eyes had been examined lately. The parent admitted to having worn glasses in the past but due to their expense she had not had them replaced after they were broken. With the parent's permission, the worker found a social agency which in cooperation with an optometrist was able to provide an eye exam and glasses at a reduced rate.

Economic

The economic functions of the family include the family's financial status, its ability to meet debts and provisions for insurance. In addition this function includes the family's teaching the children about handling money. Some questions which may be useful to assess this family function include: "Does the family have adequate health insurance or medical coverage? Do they adequately meet their debts? Do the parents work? Is the family able to meet its basic needs? Are children taught about managing money? Do family members have the information and skills needed to be wise consumers?"

> Mary's mother frequently complained about not having enough money to enjoy a movie or an occasional dinner out. When the case manager felt that the trust level was sufficient between them, she asked the parent about how the family's money was managed. The parent admitted that money matters were handled on a day-to-day basis and implied that she like to become more knowledgeable. An objective was written which included the case manager obtaining basic budgeting guidelines and forms from the public library. The case manager assisted the parent to put the information work. Mary, also, sat in on some of the discussions and showed an interest in learning to budget her part-time job earnings.

Recreation

The recreation functions of the family include participation in both individual and family oriented activities, taking time-out for rest and relaxation, and developing hobbies. the family's ability to be involved in fun and relaxing times. Questions to focus the assessment of this family function include: Do family members participate in recreational activities individually and together? What kind of activities do they enjoy? What types of hobbies have family members enjoyed in the past or thought about pursuing?

Mary mother expressed her concern that her daughter was going to get into trouble during her unsupervised time after school. Mary complained that all she had to do if she came home after school was watch television. At the case manager's prompting, an objective was written which included the case manager exploring after school recreation opportunities for Mary. It was learned that a volley ball league was forming at the YWCA which would meet two nights per week. This was an activity Mary had enjoyed in middle school and she was willing to give it a try again. The city bus could provide her transportation to the YWCA where the games were played and her mother could pick her up after work.

Socialization

The socialization functions of the family include the family's interpersonal relationships and the social activities that they are involved in. Which activities are they involved in? What kinds of activities would they like to be involved in? Do they have close friends? These are a few questions that the family advocate can ask to assess the family's functioning in this area.

Mary's mother had only one close friend from work who was about to move out of town. The case manager used this concern as an opportunity to again encourage the parent to attend a local support group for parents who cared for children with emotional problems. This time the parent was more receptive to the idea. The case manager supplied her with the time and date of the next meeting and offered to accompany her to the first session.

An assessment of a family's strength's and needs in each of the four components of the Family Systems Framework can be used by the family advocate in the three ways described below. Examples are given to illustrate those uses:

1. The assessment can be used as an inventory of family strengths so as to build the caregiver's confidence and self-esteem. For example, a family advocate may express the following thoughts to a family caregiver:

   Mrs. Smith, I know that your son is having a difficult time in school (educational function) but I think you've done a remarkable job in maintaining a meaningful family routine (domestic function) which really helps Johnny calm down.

2. Reference to family functions can be used to interpret families to other service providers. For example, the following could be expressed by a family advocate speaking to another professional on behalf of a family.

   You know, I think in your role as the state protective service worker you've had to focus upon the Smiths' problems but they also have lots of strengths. Did you know that Mr. Smith helped his daughter enroll in the summer recreation program (recreation function) and is now allowing her girl friend to join them on outings (socialization function)?

3. The components of the family systems model can also help the family advocate assess the family's needs in order to get the helping process underway. For example, during group

supervision reference to other family functions by the supervisor can avoid emphasizing the negatives.

We've spent the last few minutes expressing concerns about Mr. Brown's inability to help his daughter in school and that's an important concern. However, let's look at how they're doing in some other areas. Didn't you tell us last week that her parents finally took Mary to the dentist for braces (health function)? That decision took some mature planning and budgeting by the family.

Tools for Assessing Family Strengths and Needs

The most important tool for assessing the family's strengths is the figure which appeared at the beginning of this unit. An in-depth and ongoing review of the family's strengths and needs in each of the four components of the family systems framework is the focus of the assessment process in the Family Advocacy model.

The additional tools used below are optional and should only be used as supplements to the Family Systems approach to assessing the family's strengths and needs. These optional tools are listed and described below:

- Child Behavior Rating Scale

- Family Quality of Life Scale

Each of the tools is included in the appendices.

Child Behavior Rating Scale

This scale lists behaviors which may be causing problems for the family. It should serve as one tool for determining the priorities for family advocacy activities. Knowing what stressors the family is dealing with is an important step in learning how best to help them. The scale should also be used to point out the adolescent's strengths. The scale should not be used to emphasize the youth's problems. As with all the assessment tools, the family should be actively involved in the information gathering and results of the survey should be discussed with them.

Family Quality of Life Scale

Frequently, it is only the youth with the emotional disability who receives the attention of service providers. However, the evidence is clearly mounting that the needs and perspectives of the caregivers must be taken into consideration if the adolescent is going to live in the community on a long term basis. The Family Quality of Life Scale provides the opportunity for the family caregiver(s) to assess their own quality of life. The scale results should serve to stimulate discussion with the caregivers and as a focus of the family advocate's activities.

Guidelines for Conducting an Assessment

The following guidelines should be kept in mind by the family advocate when completing an assessment.

- Move into the assessment after the adolescent and the family have gotten to know you and the interaction feels comfortable. This point may be reached after a few hours or a number of weeks.

- When discussing an item that may be awkward or embarrassing, attempt to maintain a matter-of-fact composure.

- Keep the meeting informal and the interview semi-conversational.

- At times the youth or parent may tend to ramble or over elaborate. If it becomes counter-productive to the assessment attempt to refocus on the tasks at hand without being rude.

- Be prepared to explain meanings of words and to rephrase questions.

- Be certain the client understands the assessment tool is not a test which they can pass or fail.

- Attempt to obtain the perspective of all family members who have a significant role in caring for the youth.

- Be patient. Assessment is an ongoing process that does not have to be completed during the first meeting.

- Family caregivers are the ones who determine which strengths are in the case record.

- Encourage and assist the family caregiver to be a full partner in the strengths assessment process.

UNIT 6
THE OBJECTIVE SETTING PROCESS

Description

Unit 6 describes the standards for objectives and the process by which they are formulated and achieved with the clients. Case examples are provided.

Objectives

1. **List and explain the standards for objectives.**

2. **Describe the objective setting process.**

Activities

1. Discuss the importance of involving the clients in the objective setting and achievement process.

2. Using a case example, practice formulating objectives which meet the standards listed in this unit.

3. With the trainer first playing the role of the family advocate, role play a session in which an objective is formulated with a family caregiver.

UNIT 6
THE OBJECTIVE SETTING PROCESS

Standards for Objectives

Each of the objectives formulated with the caregiver and the youth should comply with the following standards:

1. *Objectives must be stated in positive terms.* State what it is that the family and/or youth is expected to do, rather than defining what they are expected to stop doing. For example, "Joe will play golf with Fred," rather than, "Joe will stop hanging out at the mall."

2. *Objectives must be family and/or youth oriented.* What is the family and/or youth going to achieve? For example, "Sue will participate in the Youth Symphony," rather than, "The worker will arrange for Sue to try out for the Youth Symphony."

3. *Objectives must be realistic and achievable.* Incremental steps toward each objective must be clearly stated so that progress is observable to the youth and/or the family and the worker. For example, "Gerald will attend weight lifting classes on Tuesday evening at the YMCA," rather than, "Gerald will increase his social interactions."

4. *Objectives must be measurable and observable.* Keep the objective statements clear of adjectives and adverbs and set a single measurable standard. For example, "Rita will complete the GED program," rather than, "Rita will successfully complete . . . ."

5. *Objectives must focus on resource acquisition, not behavior change or psychological change objectives.*

Description of the Objective Setting Process

Objective setting is the process by which the youth, their family and the worker set objectives to work on which when met will develop the youth's and family's strengths and meet the basic needs defined during the assessment. The process of establishing objectives with the youth and their family is a natural progression that results from the establishment of a positive trusting relationship.

Each objective setting process will be different but all of them will follow a similar sequence. The process of setting objectives with the adolescent will be first. As the worker is spending time getting to know the youth, they will need to focus the discussion on talking about what the youth would like to see different in their lives or what they would like to be involved in. During this same time period the family advocate must also be establishing a relationship with the youth's caregivers. This relationship at first will be focused more on their child and getting the parents to see the family advocate as someone who is helpful and positive for their child. The parents will have to feel comfortable with the family advocate spending time with their child and feel that their child is safe. Suggestions for building the parents' confidence in the family advocate include:

- treat them with courtesy and respect

- provide them the opportunity to express hesitation or uncertainty about your work with their child

- be clear about what information they share with you will, and will not, be kept confidential

- keep them informed of your contacts with the youth and other meetings which effect their family

- frequently ask them if they have thoughts or suggestions regarding their child's needs and progress.

The time at which the first objective is set with the family will vary depending upon how rapidly the relationship is built with the worker.

As the process of objective planning gets established with the youth a complimentary process needs to be developing with the adolescent's caregivers. Once they see that the worker is genuinely interested in their child and his or her welfare and that the family advocate includes them in a collaborative way, the parents will begin to talk about other issues than just the child's. Once this happens, the worker can follow-up on things that they would like to see different and assist in establishing a plan to achieve them. By the time the worker's relationship with the youth's parents has developed to the point that objectives are being planned with them, the worker should be spending almost equal amounts of time with both the youth individually and the family. This phase of the family advocacy process will be realized at varying points with each family.

The age and level of maturity of the youth will also play a role in determining how quickly the family caregivers are involved in the objective setting process. When working with the young child it may be appropriate (and necessary) to accomplish the bulk of objective setting with the parents, taking into account the developmental level and maturity of the youth. Many circumstances will affect the establishment of this level of cooperation and discussion in the supervision group will help the worker keep the process in perspective.

Steps in the Objective Setting Process

The following steps are included to illustrate the process by which objectives are formulated:

Step 1 - Ask the clients what they need.

Ask both the caregivers and the youth what they feel is needed for the youth to live successfully in a normal environment. This question will need to be asked frequently in a variety of ways. Most clients are not accustomed to being asked by a professional helper to state what it is they feel they need; therefore, it may take them some time to get involved. They will need a great deal of reinforcement and patience from the worker to get started in this process.

Step 2 - Inventory the family's strengths and needs.

Based upon information obtained from the Youth Quality of Life Scale, Family Quality of Life Scale, Child Behavior Rating Scale, and any other appropriate sources, make a list of the family's strengths and needs for each of the seven life domains. Share the results of this strengths and needs review with the clients and ask for their feedback regarding its accuracy.

The list of needs resulting from this mutual review with the caregivers and the youth can provide a basis for formulating objectives. The worker should keep in mind that the strengths and needs assessment is an on-going process, not simply an activity that is conducted at the outset of service to the family.

Step 3 - Prioritize the needs.

Go over the needs list with the clients and ask them what their priority is for each one. If there are any critical survival needs that are unmet (i.e., food, housing, safety, medication), these are obviously first priority to begin work on immediately! However, it is important to remember that the youth and the family decide what comes first. The worker may have a different opinion on what should be worked on first but it is the youth and the family that knows themselves best and they will have a better sense of what they need and what they feel they can accomplish. Whatever the reasons the youth and their family have for ordering the priorities, there is more likelihood of a commitment if he/she can make the choice.

Step 4 - Select an objective to work on.

Try to make this first objective a reasonable one with a high probability for success. Be clear with the youth and the family about who is to do what. Once the objective has been selected use the objective planning sheet (see Appendix) to define all of the steps necessary to complete the objective. This should be done in collaboration with the family and/or youth and in consultation with the other members of the family advocacy team when needed. The plan should lay out the specifics to successful completion of the objective. This can be a working plan that is subject to change as the process of objective implementation is developed.

Step 5 - Monitoring and follow-up.

Be sure that the client is aware of every stage of the objective setting and achievement process. Review progress towards achievement of objectives with the clients frequently. Do not hesitate to reformulate objective statements or revise action plans. Objectives should be formulated to insure success! When an objective is completed provide immediate recognition and praise to the client.

Case Examples

The following suggestions and examples are provided to help the family advocate set objectives with family caregivers:

1. Get them to identify what they want to see different in their lives.

   I know that you're used to professionals telling you what is right for your family, but I want us to work together on things that you want to change. Tell me about the things you worry most about for your daughter.

2. Reframe problems or weaknesses to identify strengths and objectives.

   It's clear you're very upset about Sarah not doing her school work yesterday and having to stay after school. But let's remember that in the past she was likely to run away or strike out at a teacher when limits were set. It seems to me that some real progress has been made and you're partly responsible for it.

3. Provide encouragement and praise to reinforce the family for its progress toward objective achievement.

   I'm super impressed that you all have stuck with your plan this week to be consistent in setting limits for Tom. Before he had been able to get away with not following rules because you two were arguing among yourselves. This time you agreed on a plan of action and talked about it as you went along. That really took a lot of energy and effort on your part.

4. Listen and observe carefully as many times an objective will be identified in informal conversation.

   It seems to me that you mentioned a similar concern about the kids not having enough clothes the last time we talked. How about we set a time to go together to the local thrift shop and see what they have? We can use my car to haul the clothes back to your house.

5. Be patient and do not push for objectives to be defined until you have established a trusting, positive relationship with the family. For some people this may take some time and if you push them the objectives will not be genuine nor will they be willing to follow through on them.

   During the first month of the family advocate's work with the Brown family it was clear they were very hesitant to allow this stranger into their family. Wisely, the worker asked some questions but primarily listened and reflected back what seemed to be the parent's concerns. During the sixth week of the working relationship the worker felt that the parents would accept a more assertive role from her and she began to make suggestions for objectives based upon comments made by the parents. The initial objectives were concrete in nature (e.g., obtaining medical care, baby sitting to allow a night out) and not too threatening.

6. When the family caregiver identifies a global or long term objective help them to break it down into achievable steps. Be sure that objectives meet the standards.

   Mrs. Smith, I think it's a great idea for you to pursue beautician's training which is something you've always wanted to do. It is a big project and I don't want you to get discouraged before it's accomplished; let's make a list of the steps necessary to achieve your objective. We should also set some reasonable times for when the steps will be achieved. After we do that we'll decide how I can best help.

UNIT 7
KEY COMPONENTS OF PROGRAM DESIGN

Description

Unit 7 describes the key program design components of the Family Advocacy Model. The setting in which the process takes place, the key actors necessary for a successful program, and service procedures are detailed. For the sake of illustration the program components are explained in the context of one setting in which the model has been implemented, a state psychiatric hospital.

Objectives

1. Develop an awareness of the impact of the environment in which the helping process occurs.
2. List the key actors (and their roles) which are necessary if the program is to be successful.
3. Describe the procedures for implementing the Family Advocacy model.

Activities

1. Discuss some of the possible reasons why many mental health practitioners work in formal settings and some the ways that such practices may hinder helping families caring for youths with emotional disabilities.
2. Identify and discuss procedures for identifying and getting to know the key actors necessary for program success.

UNIT 7
KEY COMPONENTS OF PROGRAM DESIGN

Program Design Components

Attention by program developers to the three components listed below are considered essential to the design of a successful Family Advocacy program. Each component is described in the following sections.

- the service setting
- key actors necessary for program success
- procedures for program implementation

Service Setting

The particular families which will be served by the family advocacy program will be limited to a specific geographic area due to the extensive number of contacts required. It is expected that the Family Advocacy unit will be provided office space by the sponsoring agency for record keeping, telephone contacts, and meeting rooms. However, the basic tenets of the program require the family advocate to spend the great majority of their time in the community. In order to achieve the standards established for this program it is expected that at least 50% of the family advocates' time will be devoted to contacts with the youth and their family members. In most cases, these contacts will occur in the family's home.

The initial responsibility of the family advocate is to establish a positive and productive relationship with the youth's caregivers. (For more about the importance of relationship see Unit 6. This relationship will provide the foundation for all future work with the family. It is essential that the family advocate be viewed by the caregivers as a positive and supportive person who really can help them provide care to their child. The family advocate is expected to make the initial contacts and to continue meeting with the family members where they are the most comfortable and at ease. In most cases, this will be the family's home.

> Mr. Richards was not accustomed to being treated as a full partner in his child's care and needed assistance from the family advocate to assume this role. The advocate helped by frequently asking the parent his opinion of his child's progress, actively involving him in goal setting, and helping him obtain accurate and complete information regarding his child's problems and needs.

The family advocate should extend all normal courtesies to the family when arranging contacts and during their meetings. These courtesies should include:

- scheduling appointments in advance
- being flexible as to meeting times (including evening and weekend appointments when necessary)
- advising the caregivers as to the approximate duration of the session
- adhering to that time frame
- wearing respectful and appropriate dress

- respecting the family's privacy.

The family advocate is also expected to take the lead in establishing an environment for meaningful and productive work during their contacts in the home. This responsibility includes courteously requesting that distractions be removed whenever possible (e.g., tv or radio at high volume, presence of non-participants, extremes in temperature, etc.).

Key Actors Necessary for Program Success

The youth with an emotional disability and the family which cares for them come in contact with a vast array of agencies and service providers. Some of those roles and the individuals who fill them are critical to the success of the family advocacy goal. It is important that the family advocate be aware of who these individuals are and make their active and positive involvement in the program a priority. Those individuals critical to program success are referred to below as key actors. The key actors who are considered essential for the Family Advocacy Model of family advocacy to work effectively are listed below. An explanation of their involvement and the responses required of them for program success are included. The clients themselves are not included in the list of key actors since their involvement is dealt with in more depth Unit 6, The Family-Advocate Partnership.

The particular setting in which the family advocacy model is operationalized will determine who are the key actors. Those roles will be filled by an individual(s) with a different title depending, for example, on whether the Family Advocacy unit works out of a mental health center, a public school, or the state hospital. The following descriptions pertain to key actors in the state hospital. It is important that the key actors, and the responses required of them for program success, are identified prior to program implementation. After these key actors are identified the program's philosophy and goal should be clearly communicated to them, by so doing it is hoped that their support and cooperation will be obtained to help make the program a success.

Psychiatrist

In the state hospital it is most often the psychiatrist who plays the major gate keeping role. It is this person who ultimately determines when the youth is to be returned to the community. What is more, as the primary treatment provider it is his/her approval which is necessary before a family can receive family advocacy services.

Minimum Required Responses: Approval for provision of family advocacy services to a particular family.

Social Worker

The hospital social worker who has the youth's family in his/her case load must provide the family advocate the initial access to the adolescent and the family. The social worker also plays a role as part of the hospital treatment team in assigning a family to the program. The social worker can lend considerable assistance by legitimizing the family advocacy role to other hospital staff and the state protective service worker, if one is involved.

Minimum Required Responses: Assist the family advocate to schedule initial appointments with the youth and family; serve as a communication link between the family advocates and hospital staff; clarify role of family advocates with hospital staff and discuss the project in positive terms with them.

Hospital Ward Staff

The psychiatric hospital ward staff at are responsible for the day-to-day well-being of the patients. It is the ward staff who actually control the comings and goings of their charges. Given their unique position, these workers can provide valuable insight into the youths' strengths and needs.

Minimum Required Response: Assist the family advocate in setting a schedule of meeting times to work with the youth; provide the family advocate with information about the youth's activities, behavior, strengths, and needs.

State Social Services Worker

The state social services worker plays a key role in the family's life if the youth is in state custody. Ultimately, this worker can determine when and whether the youth will be returned home. The worker also can authorize state funding for services needed by the family.

Minimum Required Responses: Communicate the value of advocate to the family members and other treatment providers; authorize funding for needed services; and coordinate treatment services.

Teacher

Each youth is enrolled in an educational setting. This setting may be within the hospital or in the normal public school system. Regardless of its location, the adolescent's teacher(s) is a key to him/her remaining in the community. Unless the adolescent can function successfully in the school setting he/she is likely to be readmitted to the hospital.

Minimum Required Responses: Provide an educational environment most conducive to meeting the youth's needs; provide the family advocate and family members with specific suggestions for making the youth's school experience positive; communicate with the youth's care givers and other key service providers about the youth's progress and needs.

Community Agencies

In order for the care takers to maintain the youth in the community they will need to make use of a variety of resources (e.g., YWCA, YMCA, Community Theatre, Parent Support Group, Recreation Department). The cooperation of staff responsible for those services will be essential if the family is to gain access to them.

Minimum Required Responses: Providing the youth and family members access to needed services.

Procedures for Program Implementation

The family advocacy process must be individualized according to the needs of the particular family which is receiving the service. Also, the setting from which the family advocates operate will affect the delivery of services. However, there are some commonalities regardless of the particular clients being served or the setting from which the family advocates work. These commonalities are described below as phases of program application. While the following illustrations pertain to the hospital setting, the general tasks outlined in each phase are pertinent to all settings.

Pre-Program Phase

The family advocacy supervisor will meet with hospital staff to make all formal arrangements necessary to conduct the program from the selected. The following are among the pre-program arrangements which must be completed:

- Office space and telephones will be obtained for the family advocates and supervisor.

- Provisions for travel reimbursement will be made.

- Key hospital personnel will be informed of the program's philosophy, goal, and operating procedures.

- Criteria for selecting cases appropriate for family advocacy services must be clearly outlined and agreed upon.

- The hospital staff who will be directly involved in the program will be identified. The importance of their cooperation will be communicated and their questions and concerns responded to.

- Hospital staff will inform the family of the availability of the family advocacy service and invite/encourage them to participate.

- Representatives of the state social services department will be contacted to solicit their support for the project. Also, formal arrangements will be made to obtain state sanction for continuing family advocacy services following a youth's discharge from the hospital.

- Screening of first level masters students and interviewing will be conducted to select the case managers to staff the project.

- Training of the family advocates will commence during the first week of their practicum and will take place during two separate four hour sessions on consecutive days. The first two training sessions will include the following topics:

  * an orientation to the program model

  * description of the client population

  * illustrations of past family advocacy work

  * orientation to the sponsoring agency, meeting key staff at that facility, introduction to the sponsoring agency's rules and regulations

  * assignment of cases.

- Additional two hour training sessions will be conducted on a weekly basis until all units of the training manual have been covered.

Initial Assessment Phase

- The family advocate will meet with hospital staff to obtain background information about the clients and the staff's assessment of the family's strengths and needs. The family advocate will review the family's hospital records for those same purposes.

Initial Contact Phase

- Each family advocate will meet with the youth and his/her family members to explain the purpose of the program and to begin establishing a working relationship. The family caregiver(s) will be asked to complete the Family Quality of Life Scale and the Child Behavior Rating Scale.

- Key actors (e.g., the state social service worker, teachers, principal, therapists) in the family's efforts to maintain the youth in the community will be contacted (after "releases of information" have been signed by the caregivers) to introduce the family advocacy program and to solicit their support on behalf of the youth.

On-going Phase

- The family advocate will contact by phone and in person the youth and his/her family members as frequently as is necessary and appropriate in order to achieve the program goal (minimum of one time per week).

- Contacts with the youth and family members will focus upon establishing and achieving objectives.

- Contacts with key actors in the family's life will take place as needed, with the purpose of the contacts aimed at achievement of the program's goal.

- Family Advocates are expected to attend and actively participate in weekly group supervision, the purpose of which is to reinforce adherence to program standards, maintain a focus on the objective setting process, provide assistance in problem solving, and to provide support.

Assessment Phase

The assessment component of this program will be conducted on an on-going basis. The methods of assessment and their purpose are listed and described in the Unit titled, "Assessing Family Strengths and Needs. A sample of each of the assessment tools is included in the Appendices.

UNIT 8
STRATEGIES FOR EXERCISING INFLUENCE

Description

This unit explains the importance of the Family Advocate developing skills for influencing other service providers on behalf of the clients. Strategies for exercising influence are described and examples provided.

Objectives

1. To develop an awareness of the importance for developing effective skills for influencing others on behalf of the clients.
2. To identify effective strategies for exercising influence.Activities
3. List and discuss reasons for developing skills for exercising influence.
4. List and discuss the major strategies for exercising influence.
5. Role play use of the different strategies for exercising influence.

UNIT 8
STRATEGIES FOR EXERCISING INFLUENCE

There are three major types of strategies for exercising influence.

- Persuasion
- Inducement
- Constraint

The strategy most pertinent to the family advocate's role is persuasion. Simons (1986) explains that "persuasion involves changing the way an individual or group perceives a set of alternatives through the provision of new information. The target is given information that influences him or her to think, feel, or act in a new way." The persuasion strategies for exercising influence listed below have great potential value for the family advocate trying to get the job done for their clients within the complex social service system.

EMPHASIZE ADVANTAGES OR REWARDS

The doctor or teacher may not realize that your way of handling a case also has advantages for them. It's easy to get caught up in power struggles which often, at best, end in a draw for the professionals and the client loses. The case manger will have more success at getting his or her point across by first being sure that the other person has actually understood the proposal being laid out (express it in a variety of ways, ask questions to be sure its understood). It can help if the family advocate suggests ways in which the proposal will benefit the other person (e.g., reducing the coordination or networking time required of that person); in other words, accentuate the positive.

> The youth's teacher was very reluctant to set-up a weekly written monitoring procedure with the care giver because she simply didn't have time for "more paper work." The case manager listened to the educator's concerns and commiserated about her increasing documentation responsibilities. The case manager offered to develop the monitoring tool and pointed out that the weekly written summary to the parent would eliminate the need for the weekly meetings with the case manager, thus saving the teacher time. With those suggestions, the teacher was willing to give the plan a try.

BE COMPREHENSIBLE

The case manager should avoid unnecessary professional jargon because the simpler and more easily understood the message the more likely it is to be accepted. Case managers should not attempt to match other professionals in their use of clinical jargon. Credibility can be gained by using clear and straightforward language with both other professionals and, especially, family caregivers. The family advocate should be quick to request that other professionals define their terms, since others present in a meeting probably do not understand what is being said either.

Example: Less effective way for a case manager to express a concern regarding a client: "Obviously, this child is experiencing an ego systonic disorder due to the maternal/paternal conflict inherent in the home."

Recommended way: "Mary seems to be hurt by the continued disagreements between her parents."

SHOW COMPATIBILITY OF VALUES

We all have values and preferences which if threatened may lead to defensiveness and resistance. Be careful to not use words or phrases which the individual might perceive as representing beliefs and practices contrary to their value commitment. Emphasize the similarities in what you are trying to accomplish (i.e., protect children). It's easy for professionals to get caught up in a competitive tug-of-war in which the families being served are the ultimate losers. Especially when communication begins to break down and defensiveness escalates, it is helpful to be single minded and repetitive about the purpose for which the professionals are brought together.

> The state social services worker and the attorney were becoming more and more critical of each other. It was apparent that the defenses were escalating. The case manager, sensing that the goal of the meeting which was to find a placement outside of the hospital for a youth, was not going to be achieved if the situation did not improve. The following statement by the case manager helped to de- escalate the disagreement and get the discussion back on track: "Listen, I know there are some legitimate differences of opinion here about what to do with Mary. But while we may disagree on some specifics, we all want to help the Smith family care for their daughter at home. So how can we help them do that?"

CITE PROVEN RESULTS

The "stepping stone approach" is often the most effective way to sell an idea. As the person sees that your suggestions work they are more likely to go along with you the next time. It may help to convince the hesitant professional to try the family advocate's suggestion if examples of successful cases are given.

> A case manager attempting to convince a hospital psychiatrist that a youth should be allowed to spend more time in the community in order to practice independent living skills may make the following statement: "You know, I've read several articles lately that have stressed the importance of youths developing independent living skills if they are going to make t outside the hospital. We tried a similar approach with the Smith family and it worked really well. Their daughter's involvement in job training was a real confidence builder for the entire family. I think the same thing could happen here. What do you think?"

ALLOW FOR TRIALABILITY

Break your idea into parts which can be tried one step at a time. Sometimes people are less threatened by an idea if they can buy into it one step at a time with the "right to cancel their subscription" at any point along the way. This approach can be effective for involving the professional who is hesitant to accept the family advocate's long range plan for a client. In keeping with this strategy it is important to clearly demonstrate results along the way.

> The psychiatrist was hesitant to allow the youth to visit his parent on the weekends because of a past history of inadequate supervision. The case manager, knowing that these visits were necessary before the child could be discharged from the hospital, suggested a plan for a single over night visit at first. With the parent's consent, the case manager also proposed that a phone call be placed to the hospital ward at a specific hour to let them know how things were going. With these safeguards the psychiatrist was willing to schedule the first visit.

LINK MESSAGES TO INFLUENTIAL OTHERS

An idea is more likely to be accepted if it is linked to someone the target likes and respects. For example:

A state social service worker may be more willing to try an idea if he or she knows another state worker has already done so.

The case manger may be able to gain a psychiatrist's support for a plan to begin vocational training with a youth by pointing out that the same approach is being tried by another doctor on a different ward.

It is often very important to obtain the approval of a supervisor before approaching a line worker with an idea. Doing so may eliminate a potential major objection from the staff member and will lend credibility to your proposal.

The case manager would be wise to learn which employees are respected by their colleagues. If these people can be sold on an idea they may become powerful advocates for implementing an idea.

AVOID HIGH PRESSURE TACTICS

Present your messages in a manner which minimizes a threat to the person's feeling of freedom. Use a two-sided message which first acknowledges the opposing point of view before stating your preference. Case managers will rarely win power struggles and if they do win the result will often be "burned bridge" which means fewer resources available to the client. The family advocate is better off using the "soft sell" approach along with persistence.

Least effective way: "Either you do it this way or I'm reporting you to you supervisor."

More effective way: "I understand that you have some serious misgivings about allowing Mary to take this part-time job because you think she will take advantage of the unsupervised time. My concern is that not allowing her to work and earn some spending money will really discourage her. Can we talk about it some more?"

MINIMIZE THREATS TO SECURITY, STATUS, OR ESTEEM

Whenever an idea might be interpreted as threatening to the individual's security, esteem, or sense of confidence such fears should be acknowledged and discussed. Use of the two sided approach in such instances reduces defensiveness and allows reason to prevail. Along with high pressure tactics, threatening approaches are counter-productive. Family advocates should be deliberate in acknowledging the other person's territory and clarifying their own roles.

The case manager was convinced that the parent was ready to care for her daughter at home but the psychiatrist was hesitant. The following statement helped to diminish the push-pull atmosphere and paved the way for a valuable discussion: "Dr. Smith, I know this is your decision to make but I feel strongly that Mrs. Brown could care for her daughter. Would you be willing to call a meeting of the hospital treatment team, state social services worker, and the parent to discuss the idea?"

UNIT 9
THE PROGRAM GOAL AND STANDARDS

Description

Unit 5 describes the goal and standards of the Family Advocacy Model. The concept of normal environments for youth is defined. Examples of client outcome, productivity, efficiency, and staff morale program standards are given.

Objectives

1. **Describe the overall goal of the Family Advocacy Model.**

2. **List and explain the purpose of the client outcome, productivity, efficiency, and staff morale standards.**

Activities

1. Discuss the importance of working with realistic and measurable program goal.

2. Discuss the implications of working with realistic and measurable standards which address the program goal.

UNIT 9
PROGRAM GOAL AND STANDARDS

Program Goal

The Family Advocacy Model is a mode of service which targets the problem of adolescents experiencing severe emotional disabilities. The goal which is formulated to address the problem encompasses the needs of the persons who care for these adolescents in their normal environments. The program design focuses upon these caregivers because it is believed that their role is essential if the adolescent is to live in the community in the most natural environment possible.

The goal of the Family Advocacy service is that adolescents with severe emotional disabilities will continue living in, or will be returned to, their most natural environments. Normal environments are considered to be those which are:

- Most family like (ideally, the youth's family itself)

- Involve community activities, such as the YMCA, YWCA, recreation programs, Boy Scouts, Girl Scouts, Youth Symphony, etc.

- Include regular school classes and activities that meet the youth's special needs.

In order to make the program goal realistic and measurable it is important that the expectations, referred to below as standards, for the worker be clear and specific. For example, "at least 50% of those adolescents receiving family advocacy services will not be rehospitalized." The specific standards which are set will depend on a variety of factors which should include, for example, the availability of a care giver for the youth, the characteristics of the youths being served (i.e., living status at the service is initiated, history of previous hospitalizations), size of case load, geographic proximity of the clients, etc.

Program Standards

As stated in the previous section, the goal of the Family Advocacy model is to keep adolescents with serious emotional disabilities in their community in normal environments. Standards which must be met when working with the adolescent client in order to meet this goal are listed in the companion manual. A basic tenet of the model is that this goal can only be realized by integrally involving the youth's family (biological parent[s], foster parents, group home, etc.) in the helping process. Standards which must be met when working with family members are outlined below.

Client Outcome Standards

Standard 1

At least 80% of the family caregivers will acquire accurate and useful information pertaining to their adolescent's disability throughout the period that the advocacy service is provided. This information will include the following:

- general characteristics of the disability

- reasonable expectations for those with the disability.

Measurement: The caregiver's satisfaction with the information provided will be assessed by a "Satisfactory" or above rating on this item in the User Satisfaction Survey which will be administered on a quarterly basis.

Standard 2

Throughout the period that the advocacy service is provided at least 80% of the family caregivers will acquire information pertaining to practical and helpful ways to respond to their child's behaviors which result from the emotional disability.

Measurement: The caregiver's satisfaction with the information provided will be assessed by a "Satisfactory" or above rating on this item in the User Satisfaction Survey which will be administered on a quarterly basis.

Standard 3

During their involvement in the advocacy program at least 80% of the family caregivers will acquire information and support which will help them feel less burdened by the demands of caring for an adolescent with severe emotional disabilities.

Measurement: The caregiver's satisfaction with the information and support provided will be assessed by a "Satisfactory" or above rating on this item in the User Satisfaction Survey which will be administered on a quarterly basis.

Standard 4

During their involvement in the program at least 80% of the family caregivers will acquire assistance in accessing the community resources they need in order to care for their child.

Measurement: The caregiver's satisfaction with the information and assistance provided will be assessed by a "Satisfactory" or above rating on this item in the User Satisfaction Survey which will be administered on a quarterly basis.

Monitoring: The results of the User Satisfaction Survey will be summarized and provided to the workers within two weeks after it is collected.

Productivity Standard

Standard 5

The family advocate will establish an average minimum of one (1) objective per week with the client family (adolescent or caregiver). This standard is to commence with week number four after family advocacy services have been established with a family and continues throughout the time that the case is in an "active" status.

Measurement: The number of completed objective statements submitted to the supervisor on a weekly basis.

Monitoring: The number of objectives formulated and achieved in each case load will be reported by the supervisor to the workers and posted in the group meeting area.

EFFICIENCY STANDARDS

Standard 6

The worker will devote a minimum of 50% of his or her allotted time for each case in direct contact (face-to-face or telephone) with the family (adolescent and/or caregiver).

Measurement: Time logs submitted to supervisor on a weekly basis.

Monitoring: The number of contacts and contact hours achieved in each case load will be reported by the supervisor to the workers and posted in the group meeting area.

STAFF MORALE STANDARD

Standard 7

The family advocate will receive the information, direction, and support from the supervisor and the support and feedback from colleagues which he/she needs to achieve the goal and standards of the program.

Measurement: The workers will select on average at least 90% "yes" responses on the Supervision Rating Form which will be provided by the supervisor following each weekly group supervision session.

The workers will be provided the opportunity to indicate in writing and anonymously their satisfaction and/or need for changes in the family advocacy program by the supervisor on a quarterly basis. At those times the workers will be provided index cards on which they are asked to list at least three aspects of the program they enjoy and three or more aspects of the program which they would like to see changed.

Monitoring: The results of the Staff Morale surveys will be summarized and provided to the workers within two weeks after they are collected.

UNIT 10
MEASURING CLIENT SATISFACTION

Description

In Unit 10 the trainee is introduced to the importance of measuring client satisfaction. The measurement activity is described as a means for determining if a positive working relationship is being established and if the caregiver's information and service needs are being met. Procedures for using the client satisfaction survey are included.

Objectives

1. Describe the importance of measuring client satisfaction with the Family Advocacy service.
2. Become familiar with the Client Satisfaction Survey.
3. List the procedures for use of the survey.

Activities

1. Discuss the ways in which professionals using traditional helping approaches measure client satisfaction.
2. List the overt and implied messages given to the client when a client satisfaction survey is appropriately used by the worker.
3. Distribute copies of the client satisfaction survey and become familiar with its format and contents.
4. Discuss the procedures for use of the survey in your program.
5. Discuss how client feedback from the survey will be used.

UNIT 10
MEASURING CLIENT SATISFACTION

Rationale

This case management model requires that a positive working relationship be established between the case manager and the clients. The client satisfaction measure provides a means for determining if that relationship has been established. Secondly, this program model requires that the clients be actively involved in the process of setting priorities and objectives for their family. Eliciting the client's level of satisfaction sends a message that their opinion is important.

Specific standards for program outcomes are included in the Family Advocacy model. Meeting these standards is important if the program goal is to be achieved. Measuring the client's satisfaction with the worker's efforts to achieve the program standards is both evidence of client-centeredness and an important source of program effectiveness data.

Measurement Tool

The client satisfaction measurement tool is included in the appendices.

Implementation Procedures

1. The adult family caregiver(s) will be asked to complete the Client Satisfaction Survey on a quarterly basis.

2. The case manager will provide the survey to the clients and explain its purpose.

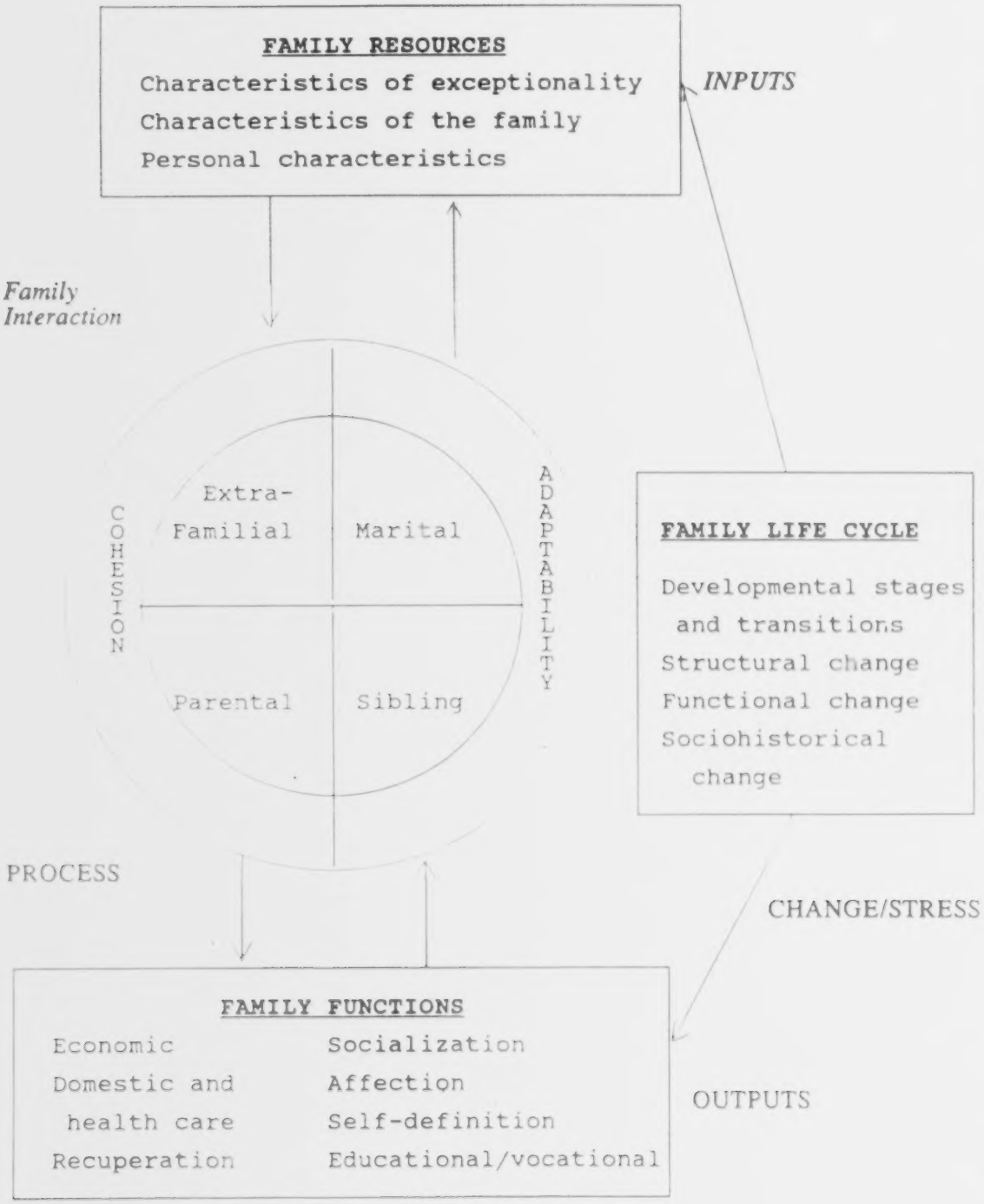
3. The clients will be provided a stamped envelope addressed to the project supervisor in which to return the completed survey.

4. The survey will be identified only by the case manager's name.

5. The results of the survey will be compiled by the project supervisor and shared with the case managers.

APPENDICES

FAMILY SYSTEMS CONCEPTUAL FRAMEWORK



Source: Turnbull, A.P., Summers, J.A., & Brotherson, M.J. (1984). *Working with families with disabled members: A family systems approach.* Lawrence, KS, Kansas University Affiliated Facility, University of Kansas.

OUTCOME MONITORING TOOLS

FAMILY ADVOCACY MANAGEMENT OBJECTIVE PLANNING RECORD (12-88)

Goal: For _____ to live in the community in the least restrictive setting possible.

Objective: _____

_____

This objective is related to the Life Domain of: (circle one)

Domestic Vocational/Educational Socialization Health Affection Leisure/Recreation

Measurable steps to achieve the objective:

WHAT	WHO WILL COMPLETE? (C OR CM)	BY WHEN	DATE ACCOMPLISHED	COMMENTS

_____ _____ _____

Client's signature Date CM signature

CASE MANAGER CONTACT SHEET/TIME LOG (11-87)

CASE MANAGER: _____ WEEK OF _____

SUNDAY	MONDAY	TUESDAY	WEDNESDAY
9:00 A.M.	9:00 A.M.	9:00 A.M.	9:00 A.M.
10:00	10:00	10:00	10:00
11:00	11:00	11:00	11:00
12:00 P.M.	12:00 P.M.	12:00 P.M.	12:00 P.M.
2:00	2:00	2:00	2:00
3:00	3:00	3:00	3:00
4:00	4:00	4:00	4:00
5:00	5:00	5:00	5:00
6:00	6:00	6:00	6:00
7:00	7:00	7:00	7:00
8:00	8:00	8:00	8:00

THURSDAY	FRIDAY	SATURDAY
9:00 A.M.	9:00 A.M.	9:00 A.M.
10:00	10:00	10:00
11:00	11:00	11:00
12:00 P.M.	12:00 P.M.	12:00 P.M.
2:00	2:00	2:00
3:00	3:00	3:00
4:00	4:00	4:00
5:00	5:00	5:00
6:00	6:00	6:00
7:00	7:00	7:00
8:00	8:00	8:00

TOTAL NUMBER OF CONTACTS WITH ADOLESCENTS DURING THE WEEK: _____
TOTAL TIME DEVOTED TO ADOLESCENT CONTACTS: _____
TOTAL NUMBER OF CONTACTS WITH CAREGIVERS: _____
TOTAL TIME DEVOTED TO CAREGIVER CONTACTS: _____

STAFF MORALE TOOLS

CASE MANAGER'S AGENDA FOR CASE DISCUSSIONS (10-87)

The following items should be the focus when presenting cases for discussion and feedback.

1. FOCUS ON STRENGTHS TO IDENTIFY GOALS.

2. KEEP IN MIND THE ADOLESCENT'S EVENTUAL NEED TO DEVELOP SKILLS FOR INDEPENDENT LIVING.

3. ALWAYS EXPLORE THE POTENTIAL FOR USE OF NATURAL HELPERS AND COMMUNITY RESOURCES WHEN ESTABLISHING GOALS.

4. FOR EACH CLIENT GOAL OR NEED AREA BRAINSTORM AT LEAST THREE ALTERNATIVES TO FULFILL THE NEED.

5. MAKE IT YOUR GOAL TO LEAVE THE SESSION WITH A PLAN OF ACTION FOR EACH OF YOUR CASES--INCLUDING SPECIFIC STEPS TO BE TAKEN BY CM.

WORKER'S GROUP SUPERVISION ASSESSMENT (5-88)

(To be completed by each worker at the end of group supervision sessions.)

CIRCLE YOUR RESPONSE

1. The session started on time.	YES	NO
2. The seating arrangement allowed each person to be clearly seen.	YES	NO
3. Interruptions occurred during the session.	YES	NO
4. Each group member was involved in the discussion.	YES	NO
5. Everyone contributed ideas and suggestions.	YES	NO
6. The atmosphere in the group was optimistic and positive.	YES	NO
7. Each person laughed at some point during the session.	YES	NO
8. Conscientious efforts that failed were celebrated.	YES	NO
9. References were made to problems, illness, or diagnoses during the session.	YES	NO
10. Common characteristics or patterns among cases were identified.	YES	NO
11. I feel like I know what to do next.	YES	NO
12. At the end of the group session I felt energized and hopeful.	YES	NO

Additional comments

SUPERVISOR'S ASSESSMENT OF GROUP SUPERVISION SESSION

To be completed by the supervisor following each group session.

1. WHICH CASES WERE REVIEWED?

2. WHICH WORKERS WERE *NOT* INVOLVED IN THE GROUP PROCESS?

3. WHO APPEARED NEGATIVE ABOUT CLIENTS OR ATTEMPTED TO SHOOT DOWN A CREATIVE IDEA OR POTENTIAL RESOURCE?

4. WHO ADMITTED A MISTAKE?

5. HOW WERE "MISTAKES" CELEBRATED?

6. WHAT NATURAL HELPERS AND/OR COMMUNITY RESOURCES WERE IDENTIFIED FOR EACH CASE?

7. HOW DID THE SUPERVISOR REFRAME PROBLEM STATEMENTS OR DIAGNOSTIC LABELS INTO STRENGTHS OR GOAL STATEMENTS?

8. WHAT PATTERNS OF WORKER BEHAVIOR (FRUSTRATIONS/STRUGGLES/ SUCCESSES/ETC.) CAN BE IDENTIFIED FROM CASE SPECIFICS?

9. WHO RECEIVED POSITIVE FEEDBACK FOR:

RECOGNITION AND/OR USE OF ADOL/FAMILY STRENGTHS

IDENTIFICATION AND USE OF NATURAL/COMMUNITY RESOURCES

CLIENT ACHIEVEMENTS AND GOAL ATTAINMENT.

10. WHAT UNMET FAMILY NEEDS OR UNAVAILABLE COMMUNITY RESOURCES WERE IDENTIFIED? WHAT CAN BE DONE TO MEET THESE NEEDS?

11. WHICH WORKER SEEMED DEFENSIVE OR FRUSTRATED? WHAT ATTEMPTS WERE MADE TO ESTABLISH MORE REALISTIC EXPECTATIONS OR TO BREAK DOWN TASKS INTO SMALLER STEPS?

ASSESSMENT TOOLS

CASE MANAGEMENT FAMILY'S PERSPECTIVE FORM

DEMOGRAPHIC INFORMATION

Name _____ Birth Date _____ Race _____

Parent(s)/Guardian's Name _____

Marital Status _____ How long? _____ Religion _____

If parent(s) absent:

Name _____ Relationship _____

Address _____

Name _____ Relationship _____

Address _____

If parent deceased, name and date _____

(Parent(s) step parent(s), foster parent(s), grandparent(s), babysitter, etc.)

Name	Relationship	Address	Phone

Other members living in household:

Name	Relationship	Address	Phone

Child's School _____ Grade _____

CASE MANAGEMENT COLLATERAL LIST AND PLAN

CASE NAME _____ CASE MANAGER _____

	PERSON/AGENCY - PHONE NUMBER	FREQUENCY OF CONTACT	PLAN
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

FAMILY QUALITY OF LIFE ASSESSMENT SCALE (9-87)

Name _____ Date _____

Please rate on a scale of 1 to 6 *how you feel* about each of the following need areas as they affect your own life. Circle the number that best describes your *current* feelings. Please circle only *one number* for each item.

		CIRCLE YOUR RESPONSE					
		VERY WELL					NOT VERY WELL
1.	Having authority and control of your children.	1	2	3	4	5	6
2.	Being respected and loved by your children.	1	2	3	4	5	6
3.	Having sources of affection, respect and support from other adults.	1	2	3	4	5	6
4.	Family members getting along with each other.	1	2	3	4	5	6
5.	Feeling needed and worthwhile.	1	2	3	4	5	6
6.	Family members sharing in the completion of household tasks.	1	2	3	4	5	6
7.	Keeping up with household tasks.	1	2	3	4	5	6
8.	Getting information about your child's progress in school.	1	2	3	4	5	6
9.	Feeling that school is a positive experience for your child.	1	2	3	4	5	6
10.	Giving your children enough advice and direction.	1	2	3	4	5	6
11.	Family members having the clothing they need.	1	2	3	4	5	6
12.	Feeling that your children are appropriately and neatly groomed.	1	2	3	4	5	6
13.	Feeling safe and comfortable in your home.	1	2	3	4	5	6
14.	Having enough heat, electricity, and water.	1	2	3	4	5	6
15.	Having enough space in your home for all family members.	1	2	3	4	5	6
16.	Being able to meet the transportation needs of your family.	1	2	3	4	5	6
17.	Keeping the house clean.	1	2	3	4	5	6

CIRCLE YOUR RESPONSE

		VERY WELL					NOT VERY WELL
18.	Having enough food for each member of the family.	1	2	3	4	5	6
19.	Being able to get the medical care your family needs.	1	2	3	4	5	6
20.	Being able to get the dental care your family needs.	1	2	3	4	5	6
21.	Being able to meet the special medical needs of your child with disabilities.	1	2	3	4	5	6
22.	Having enough money to meet your family's needs.	1	2	3	4	5	6
23.	Having enough medical insurance.	1	2	3	4	5	6
24.	Having sufficient money saved for emergencies.	1	2	3	4	5	6
25.	Being satisifed with your job.	1	2	3	4	5	6
26.	The amount of time your family spends together doing fun things.	1	2	3	4	5	6
27.	Knowing that family members get enough rest and relaxation.	1	2	3	4	5	6
28.	Having enough money for family recreation.	1	2	3	4	5	6
29.	Your family's involvement in social activities.	1	2	3	4	5	6
30.	Having the number of friends that you want.	1	2	3	4	5	6

BEHAVIOR PROBLEMS CHECKLIST

INSTRUCTIONS TO INTERVIEWER: You want to describe as accurately as possible how often problems occur.

INSTRUCTIONS TO CAREGIVER: "I am going to read a list of common problems. Tell me if any of these problems have occurred during the last week. If so how often have they occurred? If not, has this problem ever occurred?" Hand the subject the card on which the frequency ratings are printed.

FREQUENCY RATINGS

0 - never occurred
1 - has occurred infrequently (and not in past week)
2 - has occurred 1 or 2 times in past week
3 - has occurred 3 to 6 times in past week
4 - occurs daily or more often
5 - occurred frequently in past, but no longer occurs

REACTION RATINGS: How much does this bother or upset you when it happens?
0 - not at all
1 - a little
2 - moderately
3 - very much
4 - extremely

BEHAVIORS	FREQUENCY						REACTION				
1. Fights with peers.	0	1	2	3	4	5	0	1	2	3	4
2. Difficulties in completing school work.	0	1	2	3	4	5	0	1	2	3	4
3. Needing constant supervision.	0	1	2	3	4	5	0	1	2	3	4
4. Not being involved in school activities.	0	1	2	3	4	5	0	1	2	3	4
5. Unwilling to maintain proper grooming.	0	1	2	3	4	5	0	1	2	3	4
6. Unwilling to eat a proper diet.	0	1	2	3	4	5	0	1	2	3	4
7. Inability to handle money properly.	0	1	2	3	4	5	0	1	2	3	4
8. Unwilling to take responsibility for household tasks.	0	1	2	3	4	5	0	1	2	3	4
9. Not expressing affection.	0	1	2	3	4	5	0	1	2	3	4

BEHAVIORS	FREQUENCY						REACTION				
10. Not accepting expressions of affection.	0	1	2	3	4	5	0	1	2	3	4
11. Not showing respect and love.	0	1	2	3	4	5	0	1	2	3	4
12. Being constantly fatigued.	0	1	2	3	4	5	0	1	2	3	4
13. Unable to make friends.	0	1	2	3	4	5	0	1	2	3	4
14. Not having hobbies or outside interests.	0	1	2	3	4	5	0	1	2	3	4
15. Being physically aggressive towards you.	0	1	2	3	4	5	0	1	2	3	4
16. Being physically aggressive toward other family members.	0	1	2	3	4	5	0	1	2	3	4
17. Having a low opinion of self.	0	1	2	3	4	5	0	1	2	3	4
18. Being pessimistic about the future.	0	1	2	3	4	5	0	1	2	3	4
19. Needing constant reassurance.	0	1	2	3	4	5	0	1	2	3	4
20. Needing constant encouragement.	0	1	2	3	4	5	0	1	2	3	4
21. Overreacting to criticism.	0	1	2	3	4	5	0	1	2	3	4
22. Being unhappy.	0	1	2	3	4	5	0	1	2	3	4
23. Being depressed.	0	1	2	3	4	5	0	1	2	3	4
24. Requiring costly specialized care.	0	1	2	3	4	5	0	1	2	3	4
25. Difficulties in learning.	0	1	2	3	4	5	0	1	2	3	4
26. Having a short attention span.	0	1	2	3	4	5	0	1	2	3	4

BEHAVIORS	FREQUENCY						REACTION				
27. Being harmful to self.	0	1	2	3	4	5	0	1	2	3	4
28. Spending too much time alone.	0	1	2	3	4	5	0	1	2	3	4
29. Being immature.	0	1	2	3	4	5	0	1	2	3	4
30. Failing to finish things.	0	1	2	3	4	5	0	1	2	3	4
31. Being easily distracted.	0	1	2	3	4	5	0	1	2	3	4
32. Acts before thinking.	0	1	2	3	4	5	0	1	2	3	4
33. Constantly moving around.	0	1	2	3	4	5	0	1	2	3	4
34. Unable to sleep through the night.	0	1	2	3	4	5	0	1	2	3	4
35. Running away from home.	0	1	2	3	4	5	0	1	2	3	4
36. Lying.	0	1	2	3	4	5	0	1	2	3	4
37. Stealing.	0	1	2	3	4	5	0	1	2	3	4
38. Disobeying rules.	0	1	2	3	4	5	0	1	2	3	4
39. Failing to follow the normal routine.	0	1	2	3	4	5	0	1	2	3	4

CLIENT SATISFACTION MEASUREMENT TOOL

SURVEY of CAREGIVER'S SATISFACTION with CASE MANAGEMENT SERVICE

Family ID#:_____ Case Manager:_____ Date:_____

By completing this survey you will help us determine if case management is working. After you complete the survey please mail it in the self-addressed stamped envelope which was given to you.

Please indicate the extent to which you agree or disagree with each of the following statements. *Circle* one number for each statement.

1. **While receiving case management services I have learned useful information for understanding my child's emotional disability.**

STRONGLY AGREE STRONGLY DISAGREE

1 2 3 4 5 6

2. While receiving case management services I have learned useful ways to manage my child's behavior.

STRONGLY AGREE STRONGLY DISAGREE

1 2 3 4 5 6

3. While receiving case management services I have learned about ways to take care of my own emotional needs.

STRONGLY AGREE STRONGLY DISAGREE

1 2 3 4 5 6

4. My case manager and I have a positive relationship.

STRONGLY AGREE STRONGLY DISAGREE

1 2 3 4 5 6

5. The case manager has helped me to get the resources I need to care for my child.

STRONGLY AGREE STRONGLY DISAGREE

1 2 3 4 5 6

Feel free to make additional comments below or on the back of this page.